University Hospitals Sussex NHS Foundation Trust

Meeting of the Board of Directors

10:00 to 13:00 on Thursday 06 February 2025

Washington Suite Boardroom, 2nd Floor, Worthing Hospital, Lyndhurst Road, Worthing, BN11 2DH

AGENDA – MEETING IN PUBLIC

Item:1	Time: 10:00	**Welcome and Apologies for Absence** *Apologies: Jonathan Reid, Philip Hogan*	*To note*	Verbal	Presenter: Philippa Slinger
		Confirmation of Quoracy *A meeting of the Board shall be quorate and shall not commence until it is quorate. Quoracy is defined as meaning that at least half of the Board must be present this being eight Board members. With a minimum of two Executives and two Non-Executive Directors.*	*To agree*	Verbal	Presenter: Philippa Slinger
Item:2	10:00	**Declarations of Interests**	*To determine if any action is required*	Verbal	Presenter: All
Item:3	10:00	**Minutes of UHSussex Board Meeting held on 07 November 2024**	*To approve*	Enclosure	Presenter: Philippa Slinger
Item:4	10:05	**Matters Arising from the Minutes**	*To discuss*	Enclosure	Presenter: Philippa Slinger
Item:5	10.05	**Questions from the public** To receive and respond to questions submitted by the public at least 48 hours in advance of the meeting.	*To respond*	Verbal	Presenter: Philippa Slinger
Item:6	10:30	**Patient Story**	*To note*	Verbal	Presenter: Maggie Davies
Item:7	11:00	**Report from Chief Executive**	*To receive and note overview of the Trust's activities*	Enclosure	Presenter: George Findlay
		<u>Performance and Risk</u>			
Item:8	11:10	**Integrated Performance Report** • ***Chief Executive's Introduction*** • ***Patient***	*To receive and note*	Enclosure	Presenter: George Findlay

- ***People***
- ***Sustainability (financial performance)***
- ***Quality***
- ***Systems and Partnerships***
- ***Research and Innovation***
- ***National Oversight Framework***

Item:9	11:30	**Single Improvement Plan**	*To note*	Enclosure	Presenter: Katie Urch
Item:10	11:40	*At this point the Chair will invite Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.*			
Item:11	12:05	**Board Assurance Framework and Corporate Risk Register highlight report**	*To approve*	Enclosure	Presenter: Glen Palethorpe
Item:12	12:10	**Maternity Update**	*To receive papers and note declared position for CNST*	Enclosure	Presenter: Emma Chambers
	12:20	***5 Minute Break***			
		ASSURANCE REPORTS FROM COMMITTEES			
		Escalated Items Only:			
Item:13	12:25	**Report from the Research Innovation & Digital Committee from the meeting held on the 29 January 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Jackie Cassell
Item:14	12:30	**Report from Patient & Quality Committee from the meetings held on the 26 November, 17 December, 28 January**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Lucy Bloem
Item:15	12:35	**Report from People & Culture Committee from the meetings held on the 26 November, 28 January**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Paul Layzell
Item:16	12:40	**Report from Finance & Performance Committee from the meetings held on the 28 November, 29 January**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Bindesh Shah

Item:17	12:45	**Report from Single Improvement Programme Committee from the meetings held on the 27 November, 28 January**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: Paul Layzell
Item:18	12:50	**Report from Audit Committee from the meeting held on the 21 January 2025**	*To note assurance from Committee and action recommendations from the Committee*	Enclosure	Presenter: David Curley
		WELL LED & COMPLIANCE			
Item:19	12:55	**Company Secretary Report** For information only	*For information only*	Enclosure	Presenter: Glen Palethorpe
Item:20	13:00	**OTHER**			
		Any Other Business To receive any notified urgent business and action	*To receive any notified urgent business and action*	Verbal	Presenter: Philippa Slinger
Item:21	13:00	**Date and time of next meeting:** The next meeting in public of the Board of Directors is scheduled to take place at **13.30 on Monday 31 March 2025.**		Verbal	Presenter: Philippa Slinger

Supporting Appendices:

Item 12	Maternity	CNST Y6 Submission Perinatal Quality Surveillance Update ATAIN & Transitional Care	*To receive and note*
Item:14	Patient & Quality	Learning from Deaths Q3	*To receive and note*
Item:15	People & Culture	Volunteer Strategy	*To receive and approve*
Item:16	Finance & Performance	Emergency Preparedness Resilience and Response Annual Report 2024	*To receive and endorse publication to the Trust website*

Minutes

University Hospitals Sussex
NHS Foundation Trust

Minutes of the Board of Directors meeting held in Public at 10.00am on Thursday 07 November 2024, held in the Washington Suite Boardroom, Worthing Hospital, Lyndhurst Road, Worthing and virtually via Microsoft Teams Live Broadcast.

Present:

Philippa Slinger	Chair
Professor Jackie Cassell	Non-Executive Director
Lucy Bloem	Non-Executive Director
Professor Paul Layzell CBE	Non-Executive Director
Bindesh Shah	Non-Executive Director
Philip Hogan	Non-Executive Director
Wayne Orr	Non-Executive Director
Professor Gordon Ferns	Non-Executive Director
Dr George Findlay	Chief Executive
Dr Andy Heeps	Chief Operating Officer and Deputy CEO
Jonathan Reid	Chief Financial Officer
Dr Maggie Davies	Chief Nurse
David Grantham	Chief People Officer
Professor Catherine (Katie) Urch	Chief Medical Officer
Darren Grayson*	Chief Governance Officer
Roxanne Smith	Chief Strategy Officer
Sandi Drewett*	Chief Culture Officer

*Non-voting member of the Board

In Attendance:

Tim Taylor	Chief of Service Women & Children (Item 10 only)
Glen Palethorpe	Company Secretary
Tamsin James	Board and Committees Manager (Minutes)
Ben Smith	Deputy Company Secretary (Production)
Catherine Bridger	Board and Committees Manager (Production)
John Murray	Director, Board Advisory Practice, Deloitte

TB/11/24/1 WELCOME AND APOLOGIES FOR ABSENCE **ACTION**

1.1 The Chair welcomed all those present to the meeting and specifically welcomed John Murray who was in attendance from Deloitte as part of the Trust's well led process. The Chair also shared birthday wishes to Dr Maggie Davies.

1.3 There were apologies for absence received from David Curley.

TB/11/24/2 DECLARATIONS OF INTERESTS

2.1 There were no other interests declared.

TB/11/24/3 MINUTES OF THE MEETING HELD ON 01 AUGUST 2024

3.1 The Board received the minutes of the meeting held on 01 August 2024.

3.2 The minutes of the meeting held on 01 August 2024 were **APPROVED** as a correct record.

TB/11/24/4 MATTERS ARISING FROM THE MINUTES OF THE PREVIOUS MEETING

4.1 There were no Matters Arising from the previous Board meetings requiring action.

TB/11/24/5 QUESTIONS FROM MEMBERS OF THE PUBLIC

5.1 The Board received a number of questions from members of the Public in advance of the meeting. The Chair stated that due to the nature of some of the questions received which were personally identifiable it would be inappropriate to share these in an open forum. The Chair informed the meeting of the various mechanisms whereby the Trust could be of further help, these ranged from the Patient Access and Liaison Service, the Complaints Team or the Subject Access Team, the details of which were available on our website here:
https://www.uhsussex.nhs.uk/patients-and-visitors/support/pals/
https://www.uhsussex.nhs.uk/resources/how-to-make-a-complaint-3/
https://www.uhsussex.nhs.uk/patients-and-visitors/records/requests/

5.2 The Chair acknowledged the first thematic question relating to the suitability, professionalism and effectiveness of the current Executive Leadership Team. The question was prompted by a recommendation contained within the Royal College of Surgeon's report considered at the June Board meeting. It was shared that Alan McCarthy as Chair of the Trust had considered this recommendation when the RCS report was received. The Chair reflected that Alan had and had expressed his confidence in the executive team at that time. However, with Philippa Slinger being welcomed as the new Chair, it was noted that along with the Non-Executive Colleagues that consideration of this recommendation was undertaken again. It was concluded that the suitability, professionalism and effectiveness of the current executive leadership team, based on the outcome of the processes applied at appointment, the outcome of their annual appraisals and the annual fit and proper persons checks, that each Executive is suitable to hold their positions.

5.3 Professor Katie Urch then went on to acknowledge each question raised, which for reasons explained by the Chair in respect to patient confidentiality, had been grouped by theme and provided assurance through her detailed responses to those who were either in attendance,' or were viewing the live meeting online', that the matters raised within the questions themselves were taken seriously.

5.4 The Board **NOTED** the questions received by the members of the public and agreed that the subsequent detailed response would be provided individually to those who raised the question and that the answers to all the questions would be placed on the Trust's website, available here: https://www.uhsussex.nhs.uk/resources/trust-public-questions-and-answers-7-november-2024/

TB/11/24/6 PATIENT STORY

6.1 Maggie Davies introduced the Patient Story to the Board and explained that the rationale for hearing such stories at the Board, is to ensure Board members discussions are grounded in the reality of patient care, and to ensure patients are at the forefront of Board member's minds as they take decisions.

6.2 Maggie explained this patient story was provided from a complaint, using the words of the person raising the concern, demonstrating how the experience of the patient informed changes and improvements, and to stimulate Board discussions about how further improvements could be enabled.

6.3 Maggie provided the context to the patient story, relating to Planned Care, and shared the story from the patient's daughter, which resulted in them raising a complaint with the Trust regarding her mother's experience. Key reflections and actions undertaken to date were shared with the Board and pertinent points were raised for discussion relating to what further action could be taken to reduce surgical cancellations, and what support is available for carers of patients, and patients who are carers, during inpatient stays.

6.4 The Board reflected on the update, and discussed that surgery cancellation rates differ by site, and are brought about for multiple reasons. In this instance improved screening would have supported the early identification of issues that led to the cancellation and inconvenience for the patient's daughter. The Board heard that there is a group developing such a tool to improve future care. It was also noted that planning of discharge from the point of admission may have improved the organisation of onward care and reduced the overall length of stay. Work on this process has been initiated and implemented by senior nurses to ensure good communication with families, including early planning and discussions of discharge needs.

6.5 Lucy Bloem commented that the complaint triangulates with key themes highlighted in the recent inpatient survey and the also related to the nature of the Public questions received. , Andy Heeps explained to the Board that in terms of patient communication, particularly for those on the planned care pathway, the Trust now uses NetCall which aids patient communication via text message whereby they can change, confirm or cancel appointments via this service. It was noted that this service is not available on all pathways across the Trust but an approach to roll this service out was being monitored.

6.6 The Board heard from Andy Heeps regarding the improvements to the surgical pathways which has been supported by the success of the scrutiny of the 65ww improvement challenge. The Board heard that as far as is possible, sudden capacity caused by a late cancellation, is utilised.

6.7 The Board heard about the support available to patients following their discharge from hospital, and how the Trust works and supports the care packages provided through the Trust's volunteer services and through partnership with Age Concern, which continued to be monitored through the Trust's Discharge Transformation Programme.

6.8 The Chair welcomed the discussion, and the Board **NOTED** the update.

TB/11/24/7 ORGAN DONATION

7.1 The Board welcomed Dr Andrew Hetreed, Clinical Lead for Organ Donation, to the meeting to present the Organ Donation Annual Report 2023/24.

7.2 Andrew highlighted that in the 12 months from April 2023 to March 2024, the Trust facilitated 38 deceased organ donors, which resulted in 93 patients receiving a life-changing organ transplant. Sadly 28 people died on the transplant list and 829 patients still awaited a transplant in the region.

7.3 Andrew reported that there is much better collaborative working due to the environment the new Louisa Martindale Building (LMB) unit provides at the Royal Sussex County Hospital which allows dedicated space for the embedded team at the site and better visibility to the multidisciplinary team (MDT) team. NHS Blood and Transplant (NHSBT) had also noted the improvements from the use of the LMB.

7.4 It was highlighted that a Specialist Nurse for Organ Donation (SNOD) was present for 60 organ donation discussions with families during 2023/24. When compared with UK performance, the Trust was rated Bronze for SNOD presence when approaching families to discuss organ donation. The Trust was rated Silver for consent rates against UK performance.

7.5 One of the metrics the Trust scored less well on was referral rate for donation after cardiac death. There had been ongoing work including other departments who are involved in this process.

7.6 There were reported to be differing challenges across sites. A major challenge for the service across all sites had been timely access to theatre as delays going into theatre could result in organs becoming unavailable for use. George Findlay shared the good progress being made in the balancing of elective and emergency theatre capacity with that needed for the valuable work of organ donation which is being supported by the renewed cross site UHSussex policy, which will focus on the improvements in balancing access in logical and structured way.

7.7 Following questions raised by the Board relating to donation pathways, donation rates for specific areas, and the transformation processes outlined in the report, Dr Hetreed further shared the organ donation retrieval process. . It was confirmed that the details of donor and recipient families are not shared in accordance with national guidance. He added that the Trust has taken part in the UK's Potential Donor Audit and the outcome has shown the Trust had the highest consent rates in the UK (66%-70% in the 3 categories of donors). A joint approach and the involvement of Specialist Nurses for Organ Donation (SNOD) had contributed to the success in this area.

7.8 The Board heard that further opportunities to raise awareness of organ donation were being explored across the Trust and opportunities to have the Trust's minibus and pool cars decal wrapped were being explored.

7.9 The Board commended the Organ Donation team for excellent performance and results during the last year.

7.10 The Board **APPROVED** the Organ Donation report.

TB/11/24/8 CHIEF EXECUTIVE REPORT

8.1 George Findlay began by taking the opportunity to say thank you to all staff for their dedication, compassion, service and continuing to demonstrate exemplary commitment to patients to provide safe high-quality care for people living locally. He added that the last quarter had been characterised by celebration, insight and learning as thousands of staff, as well as partners and patients, had been involved and inspired by the Trust's Patient First STAR Awards, UHSussex Staff Conference and the Big Conversation engagement programme.

8.2 The staff conference was followed by the Trust's first ever Black History Month Conference, held in partnership with NHS Sussex and supported by My University Hospitals Sussex Charity. George opened the conference and took the opportunity to acknowledge the pain caused by racism and assert the Trust's steadfast commitment to addressing pervasive and glaring disparities across the organisation. George shared the improvements being undertaken within the BAME network, recruitment, and leadership, which is supported by the EDI plan overseen by the People & Culture Committee. Paul Layzell, as Chair of this Committee concurred with George's comments, and explained that the Committee has a good degree of confidence in the improvement plan

which includes the talent pipeline. David Grantham added that it would be beneficial to hold external discussions with stakeholders to gather a further understanding on diverse talent planning. The Board discussed improvements to succession planning and talent pipelines and that this would be weaved into a future Board Workshop relating to Equalities, Diversity and Inclusion.

8.3 George expressed that much more remains to be done in all the workstreams associated within the Trust's strategic improvement plan, but there was just cause for optimism as work progressed.

8.4 The Board heard that there was investment needed to deliver all the requirements within the Single Improvement Plan and that costings and sources of funds were being considered.

8.5 In recognition of the UEC improvements underway at Worthing Hospital, the Chair questioned whether patient parking options had been fully explored and whether the lack of parking availability was impacting patients attending their appointments on time. George Findlay recognised the impact the Worthing Heat Network improvement works was having on parking availability on the Worthing site but expressed that all options are being carefully monitored by the Hospital leadership teams and Estates management to leverage the best access to car parking space across our sites.

8.6 The Board echoed George's thanks to the Trust's workforce for their continued commitment to the delivery of high-quality care.

8.7 The Board **NOTED** the Chief Executive Report.

TB/11/24/9 INTEGRATED PERFORMANCE REPORT

9.1 The Chair introduced the performance report for University Hospitals Sussex and informed the Board that this report shows the Trust's performance to September 2024 and sets out the progress being made to deliver the Trust's Patient First Strategy, the NHS National Oversight Framework and the wider NHS Operating Plan.

9.2 George Findlay highlighted sections of the Integrated Performance Report and drew out the following:

9.3 During Quarter 2 more than 30,000 patients provided feedback on the care they received within the Trust. 89.5% of those patients were satisfied that they had a good or very good experience, slightly below our target of 90%. However, patients cared for only in our emergency departments reported lower levels of satisfaction. The Trust recognises timeliness of care and crowded emergency departments are a significant patient experience and quality concern and there are improvement plans in place which receive the oversight of the Single Improvement Plan.

9.4 During Quarter 2 the Trust saw continued performance challenges, and the Trust continues to work with system partners to address the large number of patients who are not able to leave hospital when medically ready to do so. The Trust has remained in the national Tier 1 process for RTT and Cancer performance; Elective activity improved considerably in quarter 2, compared to 2023/24. We continue to have some specialty specific challenges for RTT long waits. The waiting list has continued to fall since last September which means that the Trust and system capacity solutions have been higher than demand in Q2. While the performance for the Trust remains challenging in certain specialties, mitigations have been constructed which helped materially reduce

the longest waiting 65-week cohort and will continue to do so as the Trust reaches its target zero 65 Week waiters with system support by March 2025.

9.5 The financial position remains challenged with additional key drivers of increased direct costs. Enhanced cost control measures had been introduced across the Trust in an endeavour to stabilise the position and support the efficiency target. Additional measures are being considered linked to the development of a refreshed strategy, to address the underlying deficit.

9.6 George added that in delivering this very challenging agenda the Trust leadership continues to prioritise patient safety and staff well-being. We are also continuing to work with our partners in the local care and health system to identify and implement improvements.

9.7 At this point the Chair thanked George for the update and invited Board members to ask questions and discuss any pertinent areas of the Integrated Performance Report and agree any necessary actions.

9.8 Lucy Bloem emphasised the positive nature of the FFT response rates but questioned the declining drivers behind the reported staff engagement score. David Grantham explained this was multifaceted, and whilst there had been a positive shift, there remained much to do to further support staff, with actions in place on culture and the Trust's People Plan for 2024/25. George Findlay and Maggie Davies both concurred with David's comments, and it was noted that improvements were on the horizon and were being supported by the strategic roadmap to 2030, the Big Conversation, and that divisional performance improvements were in themselves being implemented seeing improved engagement.

9.9 In support of the Big Conversation, Roxanne Smith explained that over 3000 colleagues across the Trust had responded to the strategy feedback, as part of the Big Conversation, which highlighted a number of issues, from staff parking, pay equity, terms and conditions, and cultural and behavioural issues, which provided a sense of the necessary direction and planning required to overcome these challenges.

9.10 The Board reflected on the multifaceted levels of the plan and continued their support that action should be focused on transformation. Whilst noting the difficulties, there remained intensive focus on maintaining oversight of the Trust's ambition whilst continually monitoring the trajectories against the risks. to the efficiency programme. The Board agreed that it remained imperative that a focus on workforce culture is integral to the transformation plan, whilst noting the joint oversight of the wider system plan delivery.

9.11 Paul Layzell assured the Board on the reporting mechanisms feeding into the People & Culture Committee that provide continual oversight of engagement, absence, and health & wellbeing and their correlation to the wider engagement improvements.

9.12 Andy Heeps posed a question to Katie Urch and Lucy Bloem regarding the SHMI and HSMR mortality indicators, and asked how assurance regarding the renewed SHMI outlier investigations were being tracked. Katie Urch advised on the positive progress and learnings being undertaken as the coding improvements are implemented, which are feeding into the learning and mortality data being embedded into their reporting processes and tracked through patient safety incident reporting, investigations and the SJR processes. There remained further improvements to be had but the data being shared is now more fulsome giving confidence over the oversight. Lucy Bloem shared that from an assurance perspective the learnings from this remit are being

shared at the Patient & Quality Committee and there remained good triangulation across the safety domains. Lucy agreed that reporting improvements will provide Board with further assurance through the additional oversight at the Committee level.

9.13 Bindesh Shah asked if for elaboration on the H2 Cancer Care Recovery Plan. Andy Heeps referred to the pack which demonstrates the national diagnostics and treatment standards, and shared that the improvement plan is being constructed. Andy added that the cancer alliance is supporting the Trust on its improvement plans for the most challenging tumour sites.

9.14 ***ACTION: The Board asked that the Finance & Performance Committee undertake a deep dive of the Cancer and Diagnostic pathways.*** **Andy Heeps**

9.15 In relation to the Sustainability section of the Integrated Performance Report the Chair asked Jonathan Reid to provide an update on the current position. Jonathan drew the Board's attention to the metrics outlined within the report and explained that the Trust was drawing on the expertise of the Efficiency Delivery Director to support the delivery of the Cost Improvement Programme whilst overseeing the challenges that come with that. The high level of risk within some of the "closing the gap" schemes was highlighted and the clarity of Executive Director responsibility for the Efficiency Programme actions was drawn out, which included the establishment of the Delivery Board, which would be chaired by George Findlay meeting every two weeks. This will be supported by the introduction of a clear delivery accountability framework. It was highlighted that these actions could significantly enhance delivery, and ensure progress to close the gap, along with the development of the programme to achieve a longer-term plan across the next three years based upon the emerging Trust strategy and the system transformation work within Improving Lives Together.

9.16 Jonathan drew attention to the spectrum of achievable actions that would signal to the organisation that the Efficiency Programme was moving at pace and addressing longstanding issues, which would positively impact on quality and performance. Jonathan also explained that progressing the new schemes was a key component of an improved year end forecast for the Trust, but that this would require material delivery of the identified new schemes, with the Executive and Divisional leadership teams working in partnership, along with appropriate system support.

9.17 Lucy Bloem questioned the Capital Expenditure programme being below plan. Lucy highlighted that the Patient & Quality Committee had requested that the Finance & Performance Committee take into consideration the level of quality risks relating to ventilation systems when next presented with the Capital Programme and whether sufficient funds had been made available to mitigate the risks. The challenges were discussed, and it was noted that these would be taken into account through the capital planning for 2025/2026 for which the Director of Capital was due to commence shortly. Also, the use of underutilised capital monies is allocated to areas such as ventilation schemes through the continual reprioritisations of schemes.

9.18 The Board further discussed the Efficiency programme and its construction to ensure it continues to support the wider transformation within a targeted timeframe and supports the medium-term financial plan, the Trust's Strategic roadmap and the ICB plan.

9.19 The Board **NOTED** the Integrated Performance Report.

[The running order of the meeting differed to that of the agenda from this point forward and items were discussed as follows.]

TB/11/24/10 MATERNITY UPDATE

10.1 Tim Taylor joined the meeting and drew the Board's attention to the papers included in the pack and drew out the following.

10.2 In relation to the Perinatal Quality Surveillance report, the Board noted the positive data outcomes showing statistically significant reductions in both perinatal mortality rates and Hypoxic Ischaemic Encephalopathy (brain injury) rates, both measures are well below national benchmark rates for equivalent service configurations. Quality improvements within the Saving Babies Lives care bundle v3 have contributed to this; and the numbers of serious incidents (SI) now known as Patient Safety Incident Investigations (PSSIs) have also reduced. The Board did however recognise that sadly some families do experience devastating loss, and the service offers unwavering support and compassion to those affected during and after these very sad events.

10.3 Tim explained that it had been a challenging period operationally and that there had been clear triangulation with the staff engagement and feedback. The Clinical Operating Model for the Division had been confirmed to have been funded and positions were out to advert due to the vacancies in midwifery and Neonatal teams. Tim also shared that the Trust had received a letter of concern from NMSI on handover response and that the MNSI had been satisfied by the Trust's response.

10.4 The Boards attention was drawn to the Avoiding Term Admissions into Neonatal Units (ATAIN) and Transitional Care reports for Quarter 1 whereby rates were met for Worthing and St Richards but not for RSCH and PRH. It was noted that a key factor had been estate issues impacting the ability to provide transitional care on site. A primary reason for admissions to specialist care was hypoglycaemia for which there was a particular work programme in progress. It was noted that the list of compliance actions was being undertaken for assurance purposes.

10.5 The Board received a brief update on the progress in respect of the Clinical Negligence Scheme for Trusts (CNST) year 6 compliance. Tim Taylor drew out that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly and that any support required of the Trust Board has been identified and is being implemented as appropriate.

10.6 Lucy Bloem as Chair of the Patient & Quality Committee thanked Tim for the update and advised the Board that the Committee were assured over the level of detail provided within the reports.

10.7 Gordon Ferns questioned the sonography workforce challenges being experienced within the division as outlined in the report and asked what the mitigating timescales were. Tim outlined the national challenges and those challenges being experienced at both the Royal Sussex County Hospital, and at Princess Royal Hospital, which were being mitigated through Specialist Midwifery staff undertaking advanced sonography training to support the pathway, whilst working collaboratively with the national teams to address the shortage supply. Andy Heeps added that NHSE had introduced new elements to pre-term sonography resulting in scans being offered to women who are between 34-36 weeks gestation, resulting in these workforce challenges being experienced for the Trust.

10.8 The Board noted the improvements in neonatal outcomes and the reduction in admission rates, but George Findlay questioned whether these had correlated with healthier outcomes. Tim provided an overview of the transitional care model arrangements which are varied across the legacy Trust sites but outlined the intervention ambitions underway with support being received from the National teams.

10.9 The Chair shared the news of her positive experience during their visit to the Maternity team at Princess Royal Hospital and the Board asked for their thanks to be conveyed to the division for their phenomenal support following all the improvements noted.

10.10 The Board **NOTED** the:

- Perinatal Quality Surveillance Report
- Avoiding Term Admissions into Neonatal Units (ATAIN) Quarter 1
- Transitional Care Quarter 1

CNST (MIS) Y6 update

The Board held a short break at this point, when it reconvened, it remained quorate.

TB/11/24/11 SINGLE IMPROVEMENT PLAN

11.1 Darren Grayson provided an update to the Board and advised that the Single Improvement Plan focuses on nine domains: CQC; quality improvement; culture; surgery; planned care; urgent and emergency care; equality, diversity. and inclusion; specialised services; and maternity; to deliver those improvements quickly and provide assurance to the Board and its regulators. Darren provided an update on the plan's progress and its deliverables in the quarter, outlining the performance of each of the workstreams, highlighting where improvement is in line with trajectory and where there are gaps between the ambitions and commitments in the SIP.

11.2 The Board reflected on the potential change in approach which had been referenced in the report which would seek to minimise the duplication in reporting through the various management groups, and that for several improvements there is already an established oversight process in place. It was noted that the SIP Committee was always meant to be time limited as projects became new and embedded ways of working.

11.3 The Board **NOTED** the update.

TB/11/24/12 BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER HIGHLIGHT REPORT

12.1 Darren Grayson introduced the Board Assurance Framework (BAF) and accompanying Corporate Risk Register summary and explained that the report. had been received and considered by the Board Committees and reflected the views of each Committee responsible for their specific risks.

12.2 Glen Palethorpe explained that for each of the 10 strategic risks the expected assurances have been received over the period of quarter 2 enabling a determination to be made as to the opening quarter 3 score. The review of the BAF has shown for quarter 3 that the Trust continues to operate in an environment of elevated risk with only one risk achieving its target score and that risk 4.2 the target score was accepted by the Board to be significant.

12.3 Following the review by each of the Board Committees during their last round of meetings they have agreed the scores reflected in BAF for quarter 3 are

fairly represented specifically the increase in risk 3.1. The Research and Innovation Committee agreed that the description of strategic risk 6.1 should be changed as it better reflected the place research and innovation has in supporting improvement; and noted the minor risk description change for risk 6.2.

12.4 The Board discussed in detail the reduced levels of confidence that despite the actions being taken target risk scores can be achieved for risks 2.1, 3.1, 3.2, 4.1 and 5.2. It was noted that the BAF continued to record the receipt of assurances with a most prominent a mix of management and executive assurance, however there has been a number of externally provided assurances from Internal Audit, Guardian Services, FFT results. Whist there were a small number of sources of expected assurance for quarter 2 which did not materialise, the respective oversight committees did not feel these impacted on the quarter 3 scores and received information on the plans to receive these assurances over quarter 3. However, it was discussed that the nature of Quality Impact Assessments that flow through the Committees required further due diligence to be assured over the risk assessments undertaken within the BAF.

12.5 The Board **APPROVED** the respective risk scores as recorded within the Board Assurance Framework and **AGREED** that the reduced confidence in the achievement of the respective target scores was valid recognising that the respective Committees had reviewed and were recommending these risk scores as being a fair reflection of the risks facing the Trust. The Board also **NOTED** the Corporate Risk Report.

TB/11/24/13 REPORT FROM THE RESEARCH, INNOVATION & DIGITAL COMMITTEE CHAIR FROM THE MEETING ON THE 30 OCTOBER 2024.

13.1 The Chair invited Jackie Cassell, Chair of the RI&D Committee which includes the oversight of the Research and Innovation domain and digital, to update the Board on their recent meeting and the assurances received in relation to patients and research and innovation.

13.2 Jackie asked the Board to note that the Clinical Research facility remains a key matter to realise the Trust's Research Innovation & Digital ambition.

13.3 The Board **NOTED** the Research Innovation & Digital Chairs report.

TB/11/24/14 REPORT FROM PATIENT & QUALITY COMMITTEE CHAIR FROM THE MEETING ON THE 27 AUGUST, 24 SEPTEMBER, 29 OCTOBER

14.1 The Chair invited the Chair of the Quality Committee, Lucy Bloem, to update the Board on their recent meeting and the assurances received in relation to Quality.

14.2 Lucy advised the Board that the Committee would be receiving oversight of the Quality Impact Assessments supporting the various transformation projects.

14.3 It was noted that the Trust's internal auditors were supporting a review of the Quality Scorecard in order to provide clarity over the divisional ability to report against their Quality standards.

14.4 The Board **NOTED** the Patient & Quality Committee Chairs report.

TB/11/24/15 REPORT FROM PEOPLE & CULTURE COMMITTEE CHAIR FROM THE MEETING ON THE 29 OCTOBER.

15.1 The Chairman invited the Chair of the People Committee, Paul Layzell, to update the Board on their recent meeting and the assurances received in relation to People.

15.2 Paul Layzell commented that the Committee had received assurance regarding the significant improvement to medical appraisal rates, and because of the report and discussions undertaken, the Committee had been assured over the seriousness and focus given to the medical appraisal process and had confidence that the process is structured to deliver meaningful appraisals. In terms of staff engagement, the Committee had noted the correlation of the need to improve the support for reasonable adjustments with the feedback the NEDs had had within their conversations with the respective staff network chairs.

15.3 The Board **NOTED** the People & Culture Committee Chairs report.

TB/11/24/16 REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE CHAIR FROM THE MEETING ON THE 26 SEPTEMBER, 31 OCTOBER.

16.1 As finance and performance had been covered within the Integrated Performance Report item there was no further discussion under this item and the Board **NOTED** the Finance & Performance Committee Chairs report.

TB/11/24/17 REPORT FROM THE SINGLE IMPROVEMENT PLAN COMMITTEE CHAIR FROM THE MEETING ON THE 28 AUGUST, 25 SEPTEMBER, 30 OCTOBER 2024.

17.1 Paul Layzell, Chair of the SIP Committee advised the Board that the update. on the Safety Improvement Programme had largely been provided to the Board earlier in the meeting, there were no further items to escalate.

TB/11/24/18 REPORT FROM AUDIT COMMITTEE CHAIR FROM THE MEETING ON 24 OCTOBER 2024

18.1 Glen Palethorpe provided an update to Board in the absence of David Curley Chair of the Audit Committee and presented the Chair's report from the meeting held on 24 October 2024. It was noted that the Committee had received updates from the Local Counter Fraud Services, the External Auditors, and Internal Audit whereby the Committee had received updates on the Internal Audit activity.

18.2 The Board **NOTED** the Reports from the Audit Committee.

TB/11/24/19 UHSUSSEX STRATEGY – DEVELOPING OUR ROADMAP TO 2030

19.1 Roxanne Smith introduced the UHSussex 2030, 5-year strategy and provided an update on its development including the role of the Big Conversation with the Trust patients, stakeholders and workforce, and the themes outlined from that feedback would shape the strategy.

19.2 Rox explained that the Strategy would build on the progress since UHSussex was formed in 2021, through the structured conversations it will focus on understanding the Trust's identity, purpose and priorities for patients, staff and our wider communities. It will align with the system strategy within Improving Lives Together and the major transformation work currently underway. The Strategy is to be published for Q1 2025 and shared that the implementation plans will ensure that the Trust is aligning its resources with this strategy and enabling each part of the organisation to create clear plans that will contribute to the 2030 strategic objectives.

19.3 The Board praised Rox on the ambitious strategy, George questioned whether it was deliverable within the timescales outlined recognising the current pressures on staff time and resources. Rox outlined the delivery framework, and shared confidence in expediting its key components by the end of the 2024/25 financial year. Rox however did ask colleagues for additional support to target an increase in medical engagement within the staff feedback. .

19.4 The Chair thanked Rox for the update and reflected upon its timeframe for delivery by the end of March 2025 recognising there were Board decisions to be taken on how the Trust moves forward. Rox confirmed that a timeline would be made available and would be shared outside of the meeting, then the Board agreed for the next update to be provided to Public Board on the 06 February 2025. *[since the date of this meeting this item had been placed on to the February Board agenda.]*

19.5 The Board **NOTED** the update.

TB/11/24/20 COMPANY SECRETARY REPORT

20.1 Glen Palethorpe introduced the Company Secretary Report, and the Board noted the outcome of the recent Lead Governor Elections whereby Lindy Tomsett Public Governor for Chichester, was re-elected for a period of 2-years. The Board congratulated Lindy and looked forward to a further period of stability within the Governing body.

20.2 The Board also noted that Philip Hogan was now the Trust shareholder representative on the Board for Pharm@sea. The Trust has expressed its thanks to its former representative Dr Okorie for the diligence in which he undertook the role for the Trust.

20.3 It was noted that the Trust was aiming to move toward more meetings being held in public and that it was working on the implementation of this change and expected to be able to enact this for the next quarter which would see a March 2025 Board meeting in public being added to the calendar along with the already scheduled meeting in public on the 06 February 2025.

20.4 Glen drew the Board's attention to the publication of the 2023/24 Annual Safeguarding Report (covering both adults and children) and the 2023/24 Annual Infection, Prevention and Control Report, on the Trust's website for information (the link was provided in the meeting paper).

20.5 The Board **NOTED** the report and congratulated both Lindy Tomsett and Philip Hogan on their roles.

TB/11/24/21 OTHER BUSINESS

21.1 Some members of the Board raised concerns how the public questions had been shared and answered earlier in the meeting. The Chair highlighted that some questions received were seeking an answer that would contain information which was personally identifiable and as such would be inappropriate to share in an open forum, but they had been encouraged to utilise the established processes should they require more defined and detailed answers.

21.2 The Chair also reflected upon the meeting logistics and explained that a more accessible room would be made available for our future 2025 meetings.

TB/11/24/22 RESOLUTION INTO BOARD COMMITTEE

22.1 The Board resolved to meet in private due to the confidential nature of the business to be transacted.

TB/11/24/23 The Chair formally closed the meeting.

TB/11/24/24 DATE OF NEXT MEETING

24.1 It was noted that the next meeting of the Board of Directors was scheduled to take place at **10.00** on **Thursday 06 February 2025**.

Tamsin James
Board & Committees Manager
November 2024

Signed as a correct record of the meeting.

…….. Chair

..…… Date

University Hospitals Sussex NHS Foundation Trust

MATTERS ARISING
Trust Board in Public

	Meeting Date	Minute Ref	Action	Person Responsible	Deadline	Update	Status
1	Nov-24	TB/11/24/9	The Board asked that the Finance & Performance Committee undertake a deep dive of the Cancer and Diagnostic pathways.	Andy Heeps Finance & Performance Committee	Feb-25	The Cancer update has been provided at F&P Committee, and Andy Heeps has outlined work remained ongoing to benchmark optimum pathways. The improvement programme around the cancer patients waiting list continued to have a positive impact on performance. A full deeper dive on progress of the Trust-wide action plan:overarching actions would be provided to the Finance & Performance Committee in February 2025.	Open

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	7.	**Meeting:**	Trust Board in Public	**Meeting Date:**	06 February 2025
Report Title:	Chief Executive's Report				
Sponsoring Executive Director:		Dr George Findlay, Chief Executive			
Author(s):					
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	N/A
Review and Discussion	N/A	Approval / Agreement	N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB (Integrated Care Boards) / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

N/A

Executive Summary:

This report gives the Trust Board a summary of highlights from the Chief Executive and the work of UHSussex over the last quarter.

Key Recommendation(s):

The Board is asked to **NOTE** this report.

CHIEF EXECUTIVE REPORT

1.1. I wish to begin by acknowledging and commending the exceptional patient care and activity levels all our teams have achieved over the past few months, both for planned and urgent care. Across the board, colleagues have worked extraordinarily hard to deliver huge improvements for patients and it is important we acknowledge and thank them publicly for their commitment and dedication throughout yet another hugely challenging period for the NHS.

1.2. At the end of November, when our board last met in public, colleagues had reduced our overall waiting list to 118,000 patients, down from a peak of more than 155,000 patients in September 2023. We now know that this 24% decrease was the biggest absolute reduction delivered in the NHS over this period, and the biggest reduction of any multi-site acute Trust in the country.

1.3. This is an extraordinary achievement and clearly demonstrates colleagues' steadfast commitment to improving waiting times for our patients as we provide more care, treatment and diagnostic procedures than ever before. Trust-wide, teams are currently delivering 117% of pre-pandemic activity levels, which equates to more than a 10% increase year-on-year.

1.4. We know much more remains to be done to improve access for all our patients and we still have one of the largest waiting lists in the country, especially for patients waiting more than 65 weeks to access treatment. However, in line with our Single Improvement Plan published last summer, we are continuing to reduce waiting times for patients on the trajectory we set out, and we are on track to eliminate 65 week waits by the close of this financial year.

1.5. For our most challenged specialties, we are pleased to be working with the *Getting It Right First Time* (GIRFT) national improvement programme to implement new ways of working that draw upon national best practice that helps us further improve productivity and reduce waiting times for patients.

1.6. We have also implemented and locally adapted other examples of national best practice this winter to improve access to urgent and emergency care and reduce congestion in our Emergency Departments. Two initiatives that are making a significant impact are implementation of a Continuous Flow Model within our hospitals and facilitation of an Unscheduled Care Navigation Hub in Falmer, working in partnership with South East Coast Ambulance Trust (SECAmb) and colleagues from NHS Sussex and our community and mental health partners.

1.7. Under the Continuous Flow Model, a fixed number of patients requiring admission onto a ward are continuously transferred at certain times each day from the Emergency Department, regardless of whether a bed is available. It is a risk sharing 'push' initiative premised on the fact that the primary cause of congested Emergency Departments is 'exit block', not rising demand for emergency care.

1.8. The model was first introduced in our Trust by the medical division at the Royal Sussex County Hospital, before participation was broadened to the site's surgical and specialist wards, followed by all our other main hospital sites. Implementation of such a significant change has not been without its complications. It has required ward teams to adopt a new system-orientated mind-set as we ask them to balance the risk presented by the patient in front of them with the risk posed by very unwell patients in our Emergency Departments who require admission onto a specialty ward.

1.9. The set times and standard process of the Continuous Flow model, as well as the 'push' process employed, make bed management leaner and more efficient, further improving patient flow through the hospital. As a result, we have seen improvements in the number of patients being cared for in Emergency Department corridors in January. The greatest improvement has been achieved at Royal Sussex County Hospital, where this longstanding and complex issue has at times been eliminated, especially after we expanded the model to seven days a week on this site.

1.10. I wish to commend everyone involved in embedding the Continuous Flow model across our hospitals. Clinical, operational and managerial colleagues have worked together in new ways to ensure fewer patients are waiting in the Emergency Department for a bed to become available. These are often the people who are cared for in the corridor, which is an unacceptable experience for patients and one that can lead to poor outcomes.

1.11. We are committed to eliminating corridor care as swiftly as possible. This will be achieved in partnership with our health and social care partners in Sussex, as delayed discharges - or exit-block - remains the biggest single factor responsible for overcrowded Emergency Departments all around the country. On any given day, we have around 300 patients in our hospitals who no longer require our hospital services. These patients are categorised 'DRD' - they have reached their 'discharge ready date' - but due to broader issues related to the availability of community care, mental health provision or social care provided by other organisations, scores of patients cannot leave hospital.

1.12. The other innovation I wanted to share addresses this issue from the other end by asking how can we prevent people from being admitted into hospital in the first place, while still meeting their clinical needs? A new pilot launched by NHS Sussex has seen our hospital consultants work alongside Advanced Paramedic Practitioners since early December in the Unscheduled Care Navigation Hub run by South East Coast Ambulance NHS Foundation Trust (SECAmb) in Falmer.

1.13. This model is proving very successful and is an exemplar of excellent partnership working. Sussex Community NHS Foundation Trust and Sussex Partnership mental health service are also involved in the pilot, which enables paramedics to benefit from broader expertise and information while they are on scene, determining the best course of action for their patient. Previously, in many

instances, the default is to take them to A&E for further investigations. However, our consultants can access a patient's hospital notes in real time and in discussion with the paramedics use their specialist expertise and experience to provide a more tailored plan, that often does not need to include a visit to A&E.

1.14. In the first six weeks of our consultants being co-located in the Falmer hub with ambulance colleagues, we have seen a 14% reduction in ambulance attendances at Royal Sussex County Hospital. Over the same period, around 300 patients have avoided going to our Emergency Department in Brighton – instead, many have received direct referrals from the ambulance service into our Same Day Emergency Care units (SDECs) and other departments, such as our new Surgical Assessment Unit, where their needs can be met more quickly by the right specialists.

1.15. For the first time too, patients are being regularly conveyed to our new Frailty and Respiratory SDECs in the Louisa Martindale Building, which offers a completely different patient experience from arriving at the Emergency Department by ambulance, and, most importantly, quicker access to the medical expertise and investigations they require. This innovation has been welcomed by patients and staff alike, and we hope it can be extended across West Sussex following the conclusion of the Sussex-wide pilot, which also includes a similar hub in Polegate serving East Sussex.

1.16. While these innovations have undoubtedly led to some improvements, these are unfortunately perhaps best understood in relation to how much worse it could be without them. This year's seasonal pressures included an unprecedented viral 'quademic' of Covid, Flu, Noro and RSV, all taking their toll on the communities we serve, our staff and everyone working across the entire health and social care system in Sussex. The bigger picture unfortunately remains extremely challenged, and despite improvements in many areas, our performance remains below the standards we are striving to deliver.

1.17. However, our Single Improvement Plan launched last summer continues to deliver steady progress and is designed to lay the strong foundations upon which our new Trust Strategy 2025-2030 will be built. Our *Big Conversation* engagement programme concluded in December, with more than 12,700 individual statements of feedback received over a five-month period to inform the new strategy. Our intention was to gather good quality feedback from the widest possible range of groups, individuals, staff members, charities, partners, stakeholders and members of the public. Our strategy team has done an excellent job to achieve this, and we are now using all this intelligence to map out the strategic priorities which will lead to the biggest improvements for patients.

1.18. Launching and implementing our new Trust Strategy this year is a significant endeavour and a key milestone in the evolution of University Hospitals Sussex. I am looking forward to sharing much more detail in forthcoming board meetings, and I am pleased we will have much more time to discuss what our strategy means

for the communities we serve as we double the number of board meetings we hold in public each year. We are committed to open and transparent leadership, and we want to provide greater opportunities for public scrutiny, engagement and involvement in both our Trust and our ambitious plans for the future.

1.19. At our next board we will be focusing on improvements made to our surgical services, and in particular providing an update on the Royal College of Surgeon's review published last year. A significant amount of work has taken place and it is important we bring this back to board for further discussion. Additionally, our Surgery and Education teams have been buoyed by some welcome news in January from the General Medical Council, which has revoked enhanced monitoring status of our foundation doctor training in general surgery, which had been in place since 2016.

1.20. In a letter to the Trust, the GMC commended our work to improve the training of new surgeons at Royal Sussex County Hospital. Our focus has been on creating a safe and supportive environment for high quality medical training, provided through strong leadership from our consultants. Recognition of this by an external regulator is an excellent vote of confidence in our approach, as is the reintroduction by NHS England of senior surgical resident doctors training last October, and the fact our trainees are feeling positive and recommending placements to their peers.

2. RECOMMENDATIONS

2.1 The Board is asked to **NOTE** the Chief Executive Report.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	8.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Integrated Performance Report				
Sponsoring Executive Director:	Dr George Findlay, Chief Executive				
Author(s):	Executive Directors/Corporate Directors				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	N/A
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

The Trust has a statutory requirement to report performance to the board against the NHS National Oversight Framework.

Communication and Consultation:

Executive Summary:

I am pleased to introduce the Integrated performance report for University Hospitals Sussex. It shows our performance to December 2024 and sets out the progress we are making to deliver the Trust's Patient First Priorities, the NHS National Oversight Framework and the NHS Operating Plan.

Key Recommendation(s):

The Board is asked to **NOTE** this report.

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Integrated Performance Report

December 2024

University Hospitals Sussex
NHS Foundation Trust

Chief Executive Summary

Please see enclosed the performance report for University Sussex Hospitals. It shows our performance to December 2024 and sets out the progress we are making to deliver the Trust's Patient First priorities, the NHS National Oversight Framework and the NHS Operating Plan. My summary highlights our performance against some of the key metrics with more detail provided in the body of the report.

During Quarter 3 more than 30,000 patients provided feedback on the care they received within the Trust. 88.0% of those patients were satisfied that they had a good or very good experience, below our target of 90%. This remains consistent with previous quarters of 24/25. Trust-wide ED average positive reported experience is above the national average. The urgent and emergency care improvement plan continues to be implemented to improve the length of waits in our departments and user experience. Work is also underway in other parts of the patient pathway to identify opportunities to improve experience for our patients.

From a quality perspective, there has been continued improvement in the SHMI mortality rate - a trend that has continued across the year. There has been an increase in falls across October and November but this has reduced back in December to 255 IP falls and is in line with more recent trends. Our falls rate is 4.35 per 1000 bed days and below the Trust rolling average. With respect to Harm caused within our care, since the implementation of DCIQ, incident reporting has increased by 16%, this is a positive sign of a learning and safety culture. The latest reported month has seen an improvement from a peak in October and is within the average for the last 12 months of reporting. Themes for incidents include patient harm from patient deterioration and lost to follow up, cancer, surgery delays, patient flow and lost to follow-up/waiting times in neurology/ophthalmology

Across quarter 3 the Trust experienced seasonal challenges which has further been compounded by Flu, respiratory and IPC challenges restricting bad capacity to manage urgent care flow. Performance overall in December has worsened since from a more positive position of 73% in October 24 by 1.1%. By site, the 4 large sites saw a reduction in performance whilst RACH improved significantly (+11.2% to 91.0%). Performance for UHSx was the same as Dec 24 with an increased number of attendances For context UHSx was ranked 76 out of 123 providers in Dec. Our hospitals continue to operate at a high level of occupancy at c95% which poses challenges to flow through the emergency pathway. We continue to work with system partners to address the large number of patients who are not able to leave our hospital when medically ready to do so.

The Trust has remained in the national Tier 1 process for RTT and Cancer performance. Elective activity improved in quarter 3, compared to 2023/24. We continue to have some specialty specific challenges for RTT long waits however. The waiting list has continued to fall since September-23 which means that the Trust and system capacity solutions continue to reduce the amount of patients waiting as well as the longest waits. While the performance for the Trust remains challenging in certain specialties, mitigation plans continue to deliver improvements with the ambition to deliver zero 65 Week waiters with system support by March-25.

Staffing indicators continue to improve or have remained stable, Staff engagement has seen a drop to October levels but a general improvement since August. Actions targeting improvement are underway including those regarding culture and a 'people plan' for 2024/25.

The Trust originally submitted a deficit financial plan of £26.5m for 2024/25, which was revised to deficit financial plan of £19.47m (excluding deficit support funding). The Trust received £19.47m of deficit support in October 2024, which further revised the financial plan for 2024/25 to breakeven. The actual deficit at December 2024 is £26.64m, against a planned deficit of £11.55m, which is £15.09m adverse to plan.
The Trust Board has approved a forecast outturn deficit of £40.4m, based upon the Trust receiving £31.5m of ERF.

The Trust leadership continues to prioritise patient safety and staff well-being during seasonal pressures. There are positive movement in a number of key operational metrics in planned care, cancer and diagnostics which are set to improve further across Q4.

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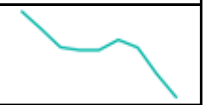
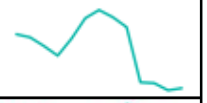
True North Metrics

	Patient First Domain	Metric	Value	Target	Trend
Pt	Patient	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	88.0%	90.0%	
P	People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.32	7.06	
S	Sustainability	Financial Stability - Variance from breakeven plan YTD	-15,090k	0k	
Q	Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	103.8	100.0	
Q	Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	581		
SP	Systems & Partnerships	A&E and Emergency flow - % treated and admitted/discharged within 4 hours	63.4%	78.0%	
SP	Systems & Partnerships	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	63.86%	70.00%	
SP	Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	561	0	
SP	Systems & Partnerships	RTT Elective care - >=65 Weeks	2278	0	
SP	Systems & Partnerships	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	14:47	11:00	
RI	Research & Innovation	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	48	35	

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Patient

	Metric	Target
True North	Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good	90.0%

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Patient First Domain

The Patient True North is for patients to have excellent care every time. The patient true north is measured using the friends and family test (FFT).

Based on available FFT data, the significant majority of patients (88% at the end of December 2024) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to each quarter throughout 2023/24 and Q1 and Q2 2024/25 against a target of 90%, although there has been a small reduction in patient reported experiences over the past 12 months.

Surveys are distributed for inpatients, outpatients, maternity and A&E, in line with national requirements. Trust-wide ED average positive reported experience is above the national average, although the gap has closed. Patient reported experience of A&E closely aligns to 4-hour performance. Inpatient reported experience, with 92.5% of patients reporting their care as good or very good, remains slightly below the national average of 95%, with the exception of at PRH. However, this is mainly due to how the data is collected with some parts of the emergency floor included in inpatient data, with this confounding the result slightly downward as patients provide a lower score when they have experienced longer waits. Overall outpatient reported experience is 96% - above the national average of 94%. Maternity patient experience is just above national averages at 94%.

The most prevalent theme in negative reviews is waiting, in particular for care and treatment, or for a bed, in A&Es. As such, there is a correlation between our patient true north and urgent care performance, in particular 4 hours. Other themes in negative experiences include appointment cancellations, staff attitude and behaviour, inpatient care and discharge. Our fundamental standards of care programme is raising inpatient care standards through audits on handwashing, falls, patient experience and nutrition, amongst others. Our charities-funded 'Welcome Standards' programme is improving customer service, with increasing numbers of patients providing positive feedback about receptions.

Emergency department improvements are overseen by F&P breakthrough objectives with A&E performance correlating with patient reported experience. An urgent and emergency care improvement plan is now in place as part of the Trust's single improvement plan, with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times.

To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. The Welcome Standards programme is being rolled out to improve experience of reception and those in greeting roles. Other support to improve communication with patients is also being delivered including CAIT training and managing difficult conversations. Changes to the visiting policy will support improved family engagement.

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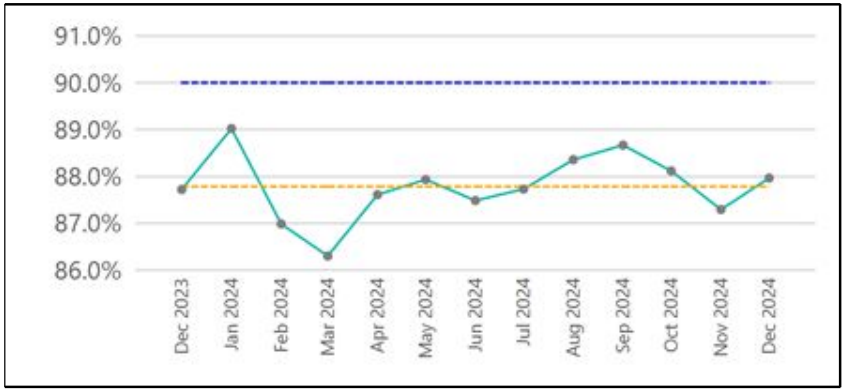
True North

Metric: Patient experience - To have 90% or more of patients rating FFT surveys as Very Good or Good

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
87.7%	89.0%	87.0%	86.3%	87.6%	87.9%	87.5%	87.7%	88.4%	88.7%	88.1%	87.3%	88.0%

Overview

The Friends and Family Test (FFT) involves a survey being distributed to ask patients to rate their care on a scale of very good (1) to very poor (5) and to give a reason for their score. The survey is grouped into four touchpoints – A&E, maternity, inpatients and outpatients.
Based on available FFT data, the significant majority of patients (88% at the end of December 24) are satisfied that they have a good or very good experience, based on more than 30,000 responses. This is comparable to each quarter throughout 2023/24 and Q1 and Q2 2024/25 against a target of 90%, although there has been a small reduction in patient reported experiences over the past 12 months.



What the chart tells us

Overall, Trust FFT positive rating remained approximately 88% in quarter. As such, the patient true north ambition of 90% was not met.
Trust-wide A&E average positive reported experience is above the national average although the gap has closed.
Patient reported experience of ED closely aligns to 4-hour performance.
Maternity services rated above 90% for all sites. Average inpatient positivity was 92.5% against a national average of 95% and outpatients averaged 96% against a national average of 94%.
The most prevalent theme in negative reviews is 'waiting'.
Medicine divisions having lower overall positive ratings than other divisions due to ED data being included. When ED figures are not included, all divisions achieve a patient positivity rating of above 90%.

Intervention and Planned Impact

Emergency department improvements are overseen by F&P breakthrough objectives with A&E performance correlating with patient reported experience. An urgent and emergency care improvement plan is now in place as part of the Trust's single improvement plan, with the aim of reducing 4 hour and 12 hour waits, and ambulance handover times.
To improve inpatient care, patient experience audits are being undertaken on the wards to identify concerns early for resolution as part of the fundamental standards of care programme. The Welcome Standards programme is being rolled out to improve experience of reception and those in greeting roles. Other support to improve communication with patients is also being delivered including CAIT training, and managing difficult conversations. Changes to the visiting policy will support improved family engagement.

Risks/Mitigations

Themes in negative patient feedback continue to relate to waiting times on site, clinical treatment, communication and staff behaviours as detailed within the Patient Experience Strategy. As such, the key risks to patient reported experience are A&E performance and care and communication by clinical staff.

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Watch Metrics for Patient

Metric	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Patient experience - Number of complaints	74	102	108	125	132	125	116	121	126	143	113	106	107
Patient experience - Total open formal complaints	768	406	378	383	434	437	412	374	352	343	316	304	294

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People

	Metric	Target
True North	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	7.06

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Patient First Domain
The Trust's workforce / people KPIs remain broadly stable or improving although there remains much to do to further support staff and improve. The Trust identified priorities for action on culture and in a 'people plan' for 24/25 and continues to pursue these while planning for 25/26. As expected, the challenges the Trust has faced in 24/25 and some of the changes necessary to deliver improved operational performance have impacted morale and motivation of some staff, reflected in a reduced engagement score. These have been impacted by staff's perception of the quality of care they are able to provide when change takes place and when there are controls on recruitment and Trust spending as it seeks to live within resources allocated. The objective has been to at least maintain and as far as possible improve the Trust's people metrics (to the equivalent of peers) over 24/25 and the results will be known when the NHS staff survey reports in Q4. Indications are that this remains 'on track' to improve scores btu whether to the same level of peers remains to be seen. The focus in Q4 is on delivering the remaining actions and activities planned, particularly focussing on those that support reducing waiting times, urgent and emergency care and managing within resources. At the same time planning for 25-26 is taking place to support delivery of the new Trust strategy and priorities for the medium term.

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True North

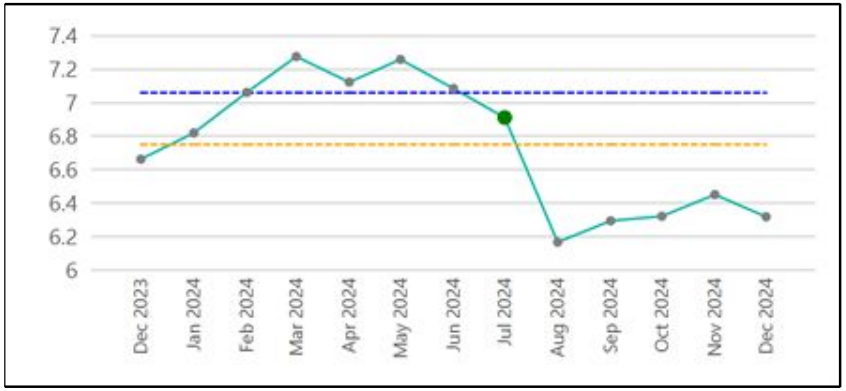
Metric: Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
6.66	6.82	7.06	7.28	7.12	7.26	7.09	6.91	6.17	6.29	6.32	6.45	6.32

Overview

The Trust's People True North is to have the most engaged staff and students in the NHS. Studies have shown that higher levels of staff engagement in the NHS are associated with higher quality of patient care and more generally that high levels of engagement are linked to improved efficiency and productivity.

The Trust measures engagement using a monthly staff survey and applying the same methodology as the national NHS staff survey to produce a composite 'engagement score'. This reflects the extent to which staff respond positively about their motivation and involvement at work and sense of advocacy for the organisation (do they speak well of it?).



What the chart tells us

Over the course of 23-24 the Trust saw a positive improvement in its engagement score, ending the year with a score of 7.3 - equivalent to the best performing Trusts in the NHS staff survey 2023. From May 24, the monthly engagement score declined month on month to a low of 6.17 in August 24. This has been driven by decline in the questions covering confidence in patient care. September, October and November 2024 saw a steady month on month improvement in the engagement. Unfortunately in December 2024 the engagement score slightly declined to 6.3. Divisions continue to review their monthly data and engagement plans. The 2024 Staff Survey results will be released in February 2025.

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Intervention and Planned Impact
Interventions and Planned Impact Extensive range of People programmes and improvement projects including: •Single Improvement Plan - Culture Programme – 5 workstreams established •Three year Equality, Diversity and Inclusion Plan – ongoing implementation of year 2 actions. •Three year Health and Well-being plan – ongoing implementation of year 2 actions and year 3 priorities reviewed and refreshed. •People Plan has eleven active improvement projects split across the 7 people promises including 5 projects that are part of the national People Promise exemplar programme. The improvement projects include addressing legacy merger pay issues, improving flexible working opportunities and improving people management policies and training. Ongoing work to ensure People and Culture priorities are aligned to the new Trust Strategy.

Risks/Mitigations
There is a risk that making improvements is challenged by lack of capacity to engage in this work eg through operational pressures and/or that external factors such as the cost of living or dissatisfaction with NHS pay and impact on staff morale. The Trust also has had a number of improvement programmes to implement in 24-25 that has involved changes for some staff to their work, which may have impact morale in the short term. These risks will, as far as possible, have been mitigated by clear communication and engagement of staff on such cases for change and the benefits they will bring. The Trust has policies and procedures to cover organisational change to support staff. There is also a significant ongoing piece of engagement with Trust staff on the future medium term strategy for the Trust (developed in 'the Big Conversation').

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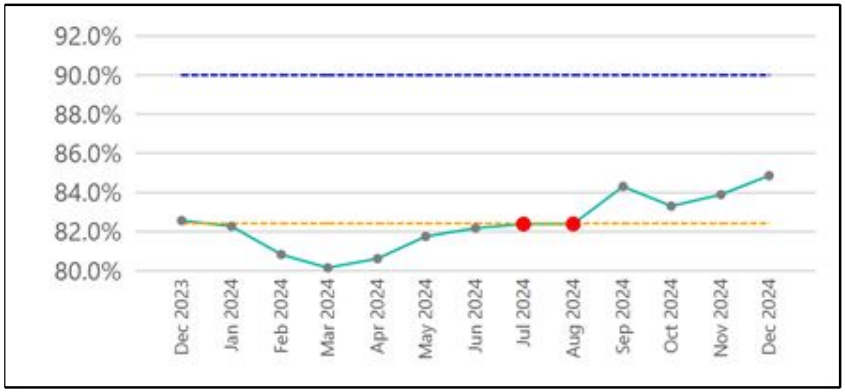
Driver

Metric: Training & development - Appraisals completed

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
82.6%	82.3%	80.8%	80.2%	80.6%	81.8%	82.2%	82.4%	82.4%	84.3%	83.3%	83.9%	84.9%

Overview

The metric reports completed appraisals for non-medical staff as a percentage of the non-medical workforce.



What the chart tells us

The Trust non-medical appraisal rate rose to 84.8% in December 2024, an increase of 0.9% points since November 2024 and the highest rate since Trust merger in April 2021.

By Division, performance ranges from 92.3% (CEO) to 74.7% (CGO). Four Divisions are now >= 90% target. Of particular note, Cancer Division (90.7%) is the only clinical/operational Division currently at/above target.

By Staff Group, Healthcare Scientists (75.8%) remain the notable outlier. All other Staff Groups are achieving 83.2% to 92.5%.

Intervention and Planned Impact

The steady increase in compliance reflects Divisional focus on this issue, and support from HR Business Partners.

The headline Trust-level and Divisional averages masks wide variation at local level. 48% of Cost Centres are >= 90% target (with 31% at 100% compliance). However 24% of Cost Centres are < 70% compliance (with 9% < 50% compliance).

Risks/Mitigations

Well conducted appraisal is positively associated with improved staff engagement, and in turn with reduced sickness absence, reduced turnover, improved wellbeing – and better outcomes for patients, including reduced mortality.

HRBPs are continuing to liaise with Divisional leads to improve compliance, either as part of planned A3 work or as targeted support to managers whose Cost Centre(s) are < 80% compliance.

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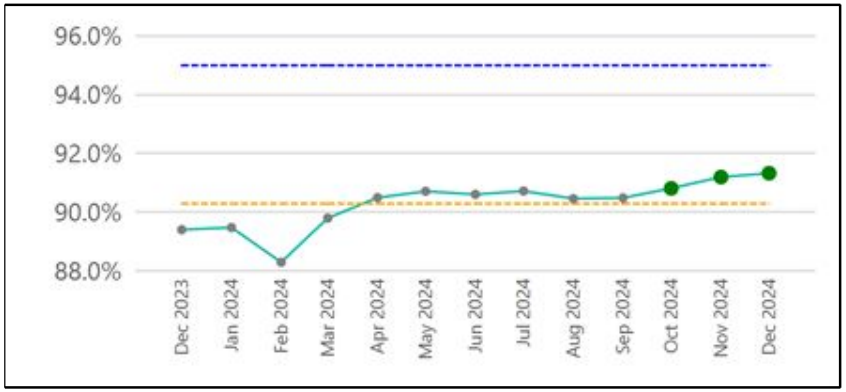
Driver

Metric: Training & development - STAM Weighted Average

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
89.4%	89.5%	88.3%	89.8%	90.5%	90.7%	90.6%	90.7%	90.5%	90.5%	90.8%	91.2%	91.3%

Overview

This metric is the STAM compliance rate all off the modules across the workforce and that should be at 90%.



What the chart tells us

Across all STAM modules are weighted average is 91.3% for all modules although we have not reached the 90% threshold in ABLS, Moving & Handling (Clinical), PBLS, Safeguarding Adults L3, Safeguarding CYP L3.

In terms of the Divisions 11/17 have a compliance rate of above 90% and 17/17 have a compliance rate of above 85%

In terms of the workforce groups 8/9 have a compliance rate of above 90% with on the Medical workforce being below at 81%

Intervention and Planned Impact

There is a national review that has been undertaken by NHSE around STAM and the expected content, delivery and 'portability' of compliance between organisations. The Trust is seeking to ensure compliance with this approach given the benefits standardisation will bring.

The approach may include reducing the expected compliance standard to 85%. That would help our overall compliance rates and bring is in line with other NHS Trusts of our size, if approved.

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Risks/Mitigations
We are following up with those that are out of date actively and we improved accessibility to Resus training by means of removing the need to do the online component before the practical session. It both need completing they can now be done in any order. We are asking people to complete their out of date STAM at point of applying for study leave and this seems to be having a positive effect. In terms of the workforce groups 8/9 have a compliance rate of above 90% with on the Medical workforce being below at 81%

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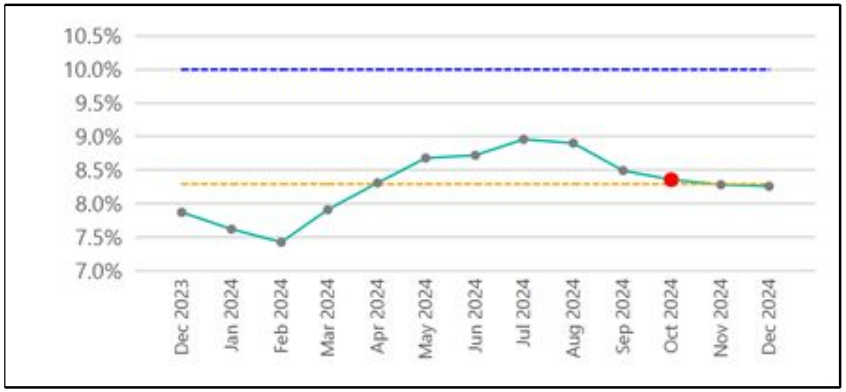
Driver

Metric: Workforce capacity - Vacancy Factor (Substantive contracted FTE) - monthly

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
7.9%	7.6%	7.4%	7.9%	8.3%	8.7%	8.7%	9.0%	8.9%	8.5%	8.4%	8.3%	8.3%

Overview

The metric describes the Trusts overall vacancy position and focuses on RN and HCA capacity.



What the chart tells us

•Positive progress continues to be made to reduce HCA and RN vacancies. Success in this area is due to a focused newly qualified recruitment campaign and a calendar of open days for RN and HCA roles
•Fortnightly recruitment performance meetings provide assurance from the resourcing function that HCA & RN candidates are being actively managed and progressed through the employment check process
•Workforce controls show impact with decrease of -23 wte staff in post for non-clinical staff
•The Trust's overall vacancy factor continues to be stable at 8.3% & green RAG rated, however, higher than 7.9% same time prior year
•The Trust employs 15,835 wte substantive staff (17,828 headcount)
•HCA vacancy factor is stable at just over 7%
•B5 RN has reduced by 1% to 11.2%

Intervention and Planned Impact

•New Head of Resourcing & Workforce Services appointed
•Recruitment deep dive paper due to be presented end of January at People and Culture Committee including 25/26 strategic resourcing principles
•Resourcing Partner appointed to work with managers on hard to recruit areas
•25/26 workforce plan in development with target to reach 4.5% HCA and 10% band 5 RN vacancy factor
•Targeted nursing recruitment campaign with social media/open days/development of employer brand and EVP
•Campaigns for specific consultant/SAS grade posts

Risks/Mitigations

•Reduced nursing student uptake reported i.e. students starting nursing courses

•Shortage of qualified nurses in the region

•Hard to recruit posts including AHP and sonography

* Move away from international nurse recruitment campaigns, focusing on recruiting graduates and via internal progression

•Impact of non-clinical vacancy freeze on resourcing team capacity

•Coordinated recruitment campaigns with support from new Head of Resourcing

•Increased leadership and subject matter expertise

•Recruitment into previously held posts to manage nursing candidate backlog and provide support for F&E recruitment where vacancies are high

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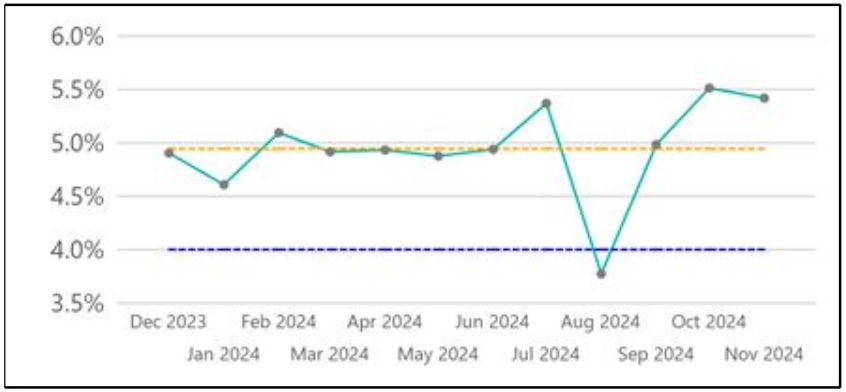
Driver

Metric: Workforce efficiency - Absence Sickness in month

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
4.9%	4.6%	5.1%	4.9%	4.9%	4.9%	4.9%	5.4%	3.8%	5.0%	5.5%	5.4%

Overview

This metric shows the Trust's in month sickness absence rate as a percentage of the staff employed.



What the chart tells us

Sickness absence rose Sep-Nov reaching highest rate of 5.5% in Oct 2024.Reflective of spikes in community:flu, respiratory cond & demonstrated by proportion of short term absence at highest for the yr during this period.Dec data not available; however weekly absence data from rostering suggests Dec a high absence month. UK's challenge with ill health&absence exposed in CIPD's Annual Health & Wellbeing at work report in 23, reporting highest reported sickness rates across UK employers over a decade. SussexICB region had highest sickness rate in south coast ICB regions Oct 24. Within SussexICB, UHSx show as midtable&positive within figures showing as the lowest proportion of absence related to mental health in Sussex region albeit still represents the highest reason for absence in the Trust.

Intervention and Planned Impact

•A dedicated team in HR continue to support the management of long term sickness absence and "hot spot areas"
•An updated Health & Wellbeing Policy has been approved and published.
•The Nursing and Midwifery Steering Group is targeting the management of absence in areas that will achieve a reduction in both sickness absence rates and bank and agency costs.
•Ongoing delivery of the Trust's 3 year health and well-being programme
•Review of Occupational health services internally and with the ICB
•Improvement plan currently in development around supporting mental ill health
•A new piece of work looking at HCA absence will shortly commence.

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Risks/Mitigations
High sickness rates impact on staff health and wellbeing, staffing levels, patient continuity of service, morale and resourcing costs. The interventions have had an impact on reducing sickness levels but this has not be sustained across a challenging autumn/winter period. Governance arrangements are in place to both monitor sickness absence with daily absence information being shared and to control the impact on services e.g. ensuring safe staffing levels are in place whilst controlling costs

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Watch Metrics for People

Metric	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Turnover (12 month)	8.4%	7.8%	7.7%	7.6%	7.4%	7.4%	7.3%	7.2%	7.1%	6.9%	6.9%	7.4%	6.7%
Workforce capacity - FTE Budgeted	16889	16896	16908	16967	17083	17137	17141	17162	17239	17310	17366	17347	17261
Workforce capacity - FTE Substantive contracted	15559	15609	15653	15624	15663	15649	15646	15624	15704	15840	15914	15910	15835
Workforce capacity - FTE Substantive contracted variance from Budget	1329	1288	1256	1342	1420	1488	1495	1538	1535	1470	1452	1437	1426
Workforce capacity - Number of leavers	94	98	91	117	76	91	89	116	169	105	113	193	93
Workforce capacity - Number of Starters	143	192	204	147	175	113	106	142	488	253	241	148	97
Workforce efficiency - Absence 12 month sickness rate	4.9%	5.0%	5.1%	5.2%	5.2%	5.2%	5.3%	5.4%	5.2%	5.4%	5.4%	5.4%	
Workforce efficiency - Absence Total in month.	15.6%	15.7%	16.3%	16.3%	16.1%	16.3%	15.5%	15.9%	13.9%	15.7%	16.5%	16.5%	

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Sustainability

	Metric	Target
True North	Financial Stability - Variance from breakeven plan YTD	0K
Breakthrough	Productivity Metric - Elective Recovery Fund Performance Actual	107.0%

Patient First Domain

The Trust's True North Domain is 'living within out means providing high quality services through optimising the use of resources' which is measured through the metric of delivering the Trust's Financial Plan.

The delivery of the Trust's financial plan has 6 key components:

1. Income & Expenditure (I&E) Performance achieving the agreed I&E plan;
2. Cash: maintaining sufficient cash balances;
3. Capital: achieving the agreed capital plan;
4. Efficiency: achieving the required efficiency programme;
5. Productivity; and
6. Agency 3.2% ceiling

Integrated Care Boards (ICBs) have a statutory duty to contain expenditure within the limits directed by NHS England, with a requirement to deliver System financial balance. In recognition of the scale of elective recovery challenge and quality agenda, and allowing for time to embed mitigations, the Sussex ICB financial revenue plan limit for 2024/25 is a £50m deficit. There is a clear expectation the deficit is mitigated in full by 2025/26.

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True North

Metric: Financial stability - Variance from breakeven plan YTD

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
YTD Actual	7.21	16.04	24.30	31.10	33.92	34.91	17.85	22.15	26.64
YTD Plan	6.52	12.44	17.61	23.93	26.76	29.47	11.12	10.93	11.55

Overview

The Trust originally submitted a deficit financial plan of £26.5m for 2024/25, which was revised to deficit financial plan of £19.47m (excluding deficit support funding). The Trust received £19.47m of deficit support in October 2024, which further revised the financial plan for 2024/25 to breakeven. The actual deficit at December 2024 is £26.64m, against a planned deficit of £11.55m, which is £15.09m adverse to plan.

The Trust Board has approved a forecast outturn deficit of £40.4m, based upon the Trust receiving £31.5m of ERF.

Elective activity performance (ERF) is 118% YTD, earning additional income of £19.21m (calculated against the 109% target) which is reflected in the reported position and offsets costs of delivery.

The cash position is £4.06m, £15.96m worse than plan. This is driven by £12.89m of 3Ts funding (this has now been received on 2nd January 2025), an unfunded year-to-M08 deficit against plan of £11.22m, reductions in provisions which are offset by £14m of revenue support funding. The revised forecast outturn will require an additional £26.4m of cash support, over and above the £14m of revenue support funding that the Trust already has.

Capital expenditure is £15.43m below plan, with expenditure of £43.91m against a plan of £59.34m. Full delivery of the plan is expected by year-end.

Efficiency performance is £10.81m behind plan, with £36.72m of efficiencies delivered year-to-date. With the inclusion of the identified opportunites, the programme has been identified in full.

The agency ceiling for 2024/25 is set at 3.2% of total pay expenditure (a reduced target from 3.7% in 2023/24). YTD agency expenditure is £17.26m, 1.8% of total pay, £7.90m below the ceiling.

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2024/25 M09 £m	Annual Plan	YTD		
		Plan / Ceiling*	Actual	Variance Fav/(Adv)
I&E (Surplus) / Deficit**	19.47	31.02	46.11	(15.09)
I&E (Surplus) / Deficit***	0.00	11.55	26.64	(15.09)
Cash	20.02	20.02	4.06	(15.96)
Capital	81.90	59.34	43.91	15.43
Efficiency	82.51	47.53	36.72	(10.81)
Agency Ceiling	30.12	25.16	17.26	7.90

* The agency ceiling is a % of pay expenditure so flexes with actuals
** Excluding £19.47m deficit support
*** Including £19.47m deficit support

What the chart tells us

The actual deficit is **£26.64m**, which is **£15.09m** adverse to plan.

Key drivers of the adverse variance to plan are: expenditure on diagnostics, high cost drugs and devices funded by fixed income (£8.3m), expenditure on undischarged patients who are medically fit to be discharged (£6.6m), expenditure to support patients with mental health needs (£4.9m), underachievement of SMSKP activity (£1.8m) and efficiency delivery below plan, which have been partially offset by non-recurrent mitigations.

The adverse cash position is impacting the Trust's ability to pay its creditors in line with the better payment practice code (BPPC).

Intervention and Planned Impact

The underlying financial deficit presents a challenging outlook to 2024/25. The actual positions in October, November and December 2024 show increased adverse variances compared to Q2, however this was mainly due to fewer non-recurrent mitigations being available to mitigate the expenditure and planned efficiency saving targets being higher, with no corresponding increase in efficiency delivery.

There remain four key areas of opportunity to reduce the overspend:

1. The Exisiting CIP Programme: The Trust has identified £82m of CIP schemes. £31m of this is anticipated to be undelivered;
2. The Financial Recovery Programme: The Efficiency Director has identified £40m of opportunity, and this continues to be evaluated and implemented with the support of the Efficiency team;
3. Grip & Control / Cost Control Measures: The Grip & Control framework is being reviewed, and particular areas of overspend / pressure will be reviewed in detail;
4. Contracting and Commissioning Review: A review of all contracting and commissioning pressures, irrespective of source, is being undertaken.

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Risks/Mitigations

The Trust in now forecasting that it will not deliver its financial plan. This is due to a number of reasons: a) under delivery against the full efficiency target, including recovery actions b) the cost of elective recovery exceeding tariff and funding envelopes, c) affordability of current pay arrangements for additional work, and d) inability to reduce the cost of Mental Health Specialling. Regular monitoring and review of these issues is taking place through the new Operational Delivery Group meetings with each Division to review financial performance and opportunities for run rate reduction. Progress is reported to the Financial Recovery Delivery Board, chaired by the Chief Executive.

The Trust has started to report deficits against the monthly plans for October, November and December 2024, even with the application of non-recurrent mitigations. The Trust will need to deliver a deficit of £4.5m in each of the remaining months to ensure the forecast outturn of £40.4m deficit is achieved. Emerging risks will require further actions to be taken to reduce the run-rate and increase efficiency delivery. This work is being led by the Efficiency Delivery Director with the support of the Executive Team.

Breakthrough

Metric: Productivity measured by the income value of activity delivered in 24/25, compared to the 19/20 baseline

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD	FY
24/25 Actual	121%	119%	124%	115%	116%	118%	118%	116%	117%				**118%**	
24/25 Target	122%	119%	120%	119%	123%	114%	112%	107%	120%	115%	115%	113%	**117%**	**116%**
23/24 Actual	104%	109%	102%	99%	101%	103%	104%	104%	107%	106%	107%	112%		**104%**

** To note prior month performance is updated post data freeze.*

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Overview

The Elective Recovery Framework (ERF) target for the Trust is 109% (income value of activity earned above the 19/20 baseline). The 24/25 Trust plan is to deliver 115.6% of the 19/20 baseline, reflecting the income value of activity to meet the requirement of zero 65 week waits.

This income performance is to be taken in conjunction with activity performance data. The performance data provides clarity of attainment of the 65-week wait performance, as consideration of increased coding depth can result in higher income performance without a corresponding attainment in performance targets.

The plan was set on the principle that overperformance will be paid at tariff, for income achieved above the 109% target and conversely, income could also be clawed back, if performance falls below the 109% target.

The YTD ERF performance at month 9 is 118% compared to the 19/20 baseline. This equates to a **+£19.21m** value variance compared to the 109% ERF Target.

The required ERF performance in the plan was 117% YTD, performance was therefore 1% above this target, resulting in the Trust reporting c £2.1m income above plan.

The ERF target 2023/24r was 105% and delivery was 104%, although NHSE implemented a year end estimated settlement negating recognition in year of the full value of productivity improvements implemented in M8, the final outcome of the appeal against this income settlement has been superseded by a revised year end methodology.

In January is was advised that a year end ERF ceiling would be allocated to ICB's based on forecast performance submitted at month 8. These figures are being assessed by the Sussex ICB and will be disseminated to Trusts in due course. It has been advised that overperformance above these forecasts will not be paid, it is not clear if underperformance will be adjusted in 2024/25.

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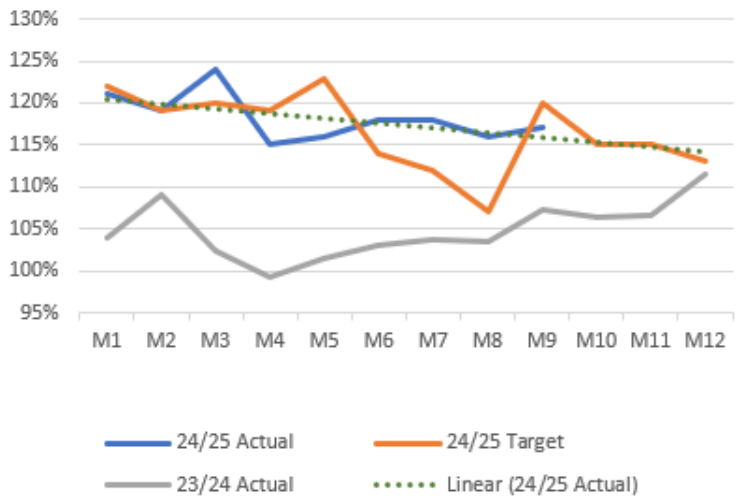

What the chart tells us

YTD performance for the 24/25 financial year is **118%** in comparison to the 2019/20 baseline target (100%). This means that the income value of activity was 9% above the 109% target, resulting overperformance of £19.21m.

The plan is phased by working days to reflect the income value of the activity performance required to meet the planned income target of 115.6%.

The chart also shows the 23/24 ERF performance, noting that last year was significantly impacted by a number of incidences of Industrial Action (IA).

Productivity initiatives, introduced in M8 last year have continued into 24/25, underpinning the higher ERF performance required to meet current year targets.

To note: NHSE have shared 24/25 ERF baselines reflecting movements from draft baselines, these are being assessed and assured.

Intervention and Planned Impact

Weekly planned care meetings monitor delivery against the required performance trajectory, with oversight being provided at fortnightly Operational Delivery Group meetings. Internal productivity and increased coding depth and capture has been sustained with income being reported close to plan

The fixed ERF ceiling implemented by NHSE will impact on further opportunities to increase income and increase % performance in comparison to 19/20 activity levels above the forecast. Maintaining a focus on ensuring all activity is captured and coded is a good discipline and will enable delivery of the forecast to be monitored.

Independent Sector capacity has been secured to support delivery in specialties with capacity constraints, affordability of utilising insourcing and outsourcing is considered.

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Risks/Mitigations
ERF baseline & actuals - NHSE advised that a year end ERF ceiling would be allocated to ICB's based on forecast performance submitted at month 8, with adjustments made in part for the prior year appeal. These figures have not yet been shared with the Trust for analysis and assurance. There is a risk that baseline adjustments and prior periods where capacity had been constrained could impact on the achievement of planned income. There is a further risk that activity increases in future months, whilst supporting the achievement of 65 week wait targets, will not be funded if activity exceeds the System ceiling. To mitigate against these risks, the discipline of increased data capture and coding improvements will continue, initiatives to understand and increase productivity through theatres are continuing.

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Quality

	Metric	Target
True North	Safety - Reduction of 5% in preventable harm - UHSx approved	
True North	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	100.0
Breakthrough	Safety - To reduce falls whilst in the care of UHSussex by 30%	202

Patient First Domain

Trustwide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.
The Quality True North for harm at UHSussex is 'Zero harm occurring to our patients when in our care', with a target to reduce the number of all harms categorised as 'low, moderate, severe harm and death' by 5%.

November has seen Trustwide increase across all sites in rate of reporting to 53.86 (per 1000 beddays) which is now fractionally below the NRLS *2022 national average of 54.9 and inching towards the Trust target of 60.

November evidenced a sustained trend in the month on month increase in reporting (3224 reported in November) and a rise in the reporting of low harm (569/581) = 98% of actual harm**). In patient falls and pressure damage are the most common themes within the low harm categories.

The highest percentage of reported patient safety incidents are graded as no harm/near miss (82%- (2643/3224). This is an ever-increasing picture of a good reporting and safety culture.

*National Reporting and Learning System replaced in 2024 with NHSE Learning from Patient Safety Events (LfPSE) - no current benchmark available or established.
**Awaiting final approval and finally approved on DCIQ only- low/moderate

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True North

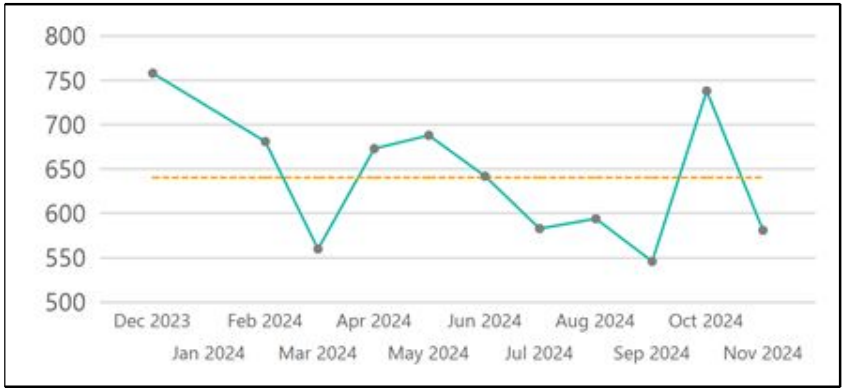
Metric: Safety - Reduction of 5% in preventable harm - UHSx approved

Dec 23	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
758	681	560	673	688	642	583	594	546	738	581

Overview

Trust-wide it is expected that patients do not suffer harm whilst in our care. However, it is recognised that there are patients who suffer new harm which is acquired during their time in hospital. This has a significant impact on patients, families , carers and staff and within the wider organisation.
The Quality True North for harm at UHSussex is 'Zero harm occurring to our patients when in our care', with a target to reduce the number of all harms categorised as 'low, moderate, severe harm and death' by 5%.
The submitted monthly incident report & harm grading (in actual numbers) for the quality scorecard via DCIQ (as graded by the reporter) requires a review, investigation and assessment for accuracy by the investigating managers. Due to capacity and or complexity, this can often take time (longer than the in-month reporting period) so in numbers, the reported (predicted in month) harm versus the final actual harm graded by the NHSE Learning From Patient Safety Events system (LFPSE) definition- has significant variation.
The quarterly reports provide the ratified and more accurate data on actual harms in numbers. In addition LFPSE has published revised harm criteria and the training for this update is now available in in conjunction with the Duty of Candour training on IRIS.

Therefore for the monthly reporting cycle for the quality scorecard, True North, QGSG and Quality Committee reports, in order to present ratified data we will now be reporting one month in arrears. So for January, we will provide a more accurate picture of approved harms from incidents reporting per 1000 bed-days for November. This follows the same methodology as FFT.
The Go-Live for the reporting of incidents module was launched in February 2024.
Since the implementation of DCIQ, incident reporting has increased by 16%, this is a positive sign of a learning and safety culture.



What the chart tells us

There were 581 preventable harms reported in November, 157 fewer than October, and below the mean average for the past 12 months.

Intervention and Planned Impact

Since 2015, the organisation has deployed the NHSE Serious Incident I Framework, using Root Cause Analysis (RCA) methodologies and approaches. Whilst a proportion of those involved in patient safety and investigations have embarked on systems-based learning through various training packages (e.g. HSIB silver investigations training), the majority of our learning response leads need to be socialised to this new approach to safety. Therefore, as part of our PSIRP and the launch for PSIRF, we have launched a complete suite of training for learning response leads and those investigating incidents.
The new Patient Safety Syllabus launched in February 2024. The training suite includes three 'levels' which have all be written and mapped out in accordance with the Patient Safety training syllabus curriculum. Those individuals identified to be learning response leads are expected to complete all three levels – level 1, 2a, and 2b.

- Level 1 – Patient Safety Fundamentals
- Level 2a – Patient Safety and Safety Science
- Level 2b – Practical applications – learning response leads

Trained to date: 250 nominated learning response leads across all divisions
DCIQ Patient Safety Improvement and Risk Management System
The Go-Live for the reporting of incidents module was launched in February 2024. The Training is available on IRIS. The Trust has purchased the DCIQ extraction tool for the BI team to allow for an accurate and seamless data feed.

Since the implementation of DCIQ, incident reporting has increased by 16%, this is a positive sign of a learning and safety culture.

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Risks/Mitigations
Themes for incidents presented to PSIRG include patient harm from patient deterioration and lost to follow up, cancer, surgery delays, patient flow and lost to follow-up/waiting times in neurology/ophthalmology. Top 5 highest trends noted as pressure damage, falls medication error/stock level discrepancy, cancellation of operation/surgery. Mental Health: High risk remains in both emergency departments and paediatric areas with Tier 4, LA and specialist placement. 2 high profile inquest pending regarding suicide on hospital premises. The Trust uses an electronic reporting system RLDATIX IQ which is used to report nationally to NHSE. There are currently no national benchmarks for reporting. In addition, all near miss, moderate/severe harm and death are reviewed by a senior panel on a weekly basis at the Patient Safety Incident Response Group (PSIRG) where the level of harm, patient/family engagement and investigation is decided. Learning is shared via early learning reviews/local learning reviews and patient safety incident investigation; themes trends and patient stories are presented at the Trust Patient Safety Group. Duty of candour complaince is audited quartely. DCIQ and Duty of Candour suite of training materials and videos now available on IRIS.

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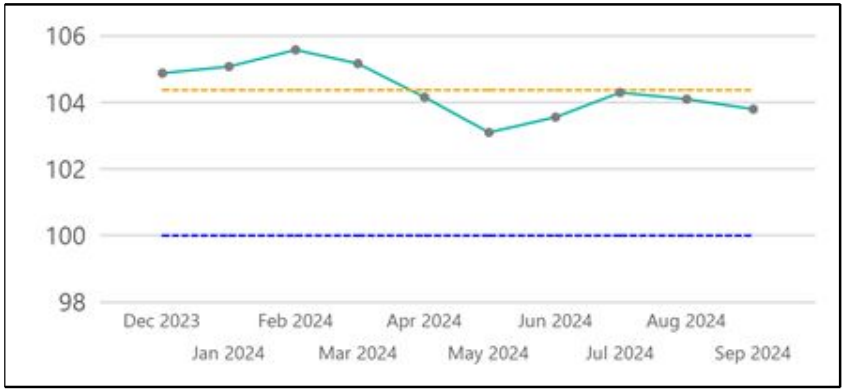
True North

Metric: Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
104.9	105.1	105.6	105.2	104.2	103.1	103.6	104.3	104.1	103.8

Overview

No Data



What the chart tells us

UHSussex SHMI (which is based on 12 months rolling data up to and including September 2024), is 103.8. This result is in band 2 which means the SHMI is as expected using an over-dispersed funnel plot, although it is an outlier based on the stricter 95% Poisson limits.
SRH (102), WH (104) and RSCH (112) site specific SHMI values are above 100. SHMI is lowest at PRH (91.8).
Out-of-Hospital SHMI is highest at PRH (113) the linear trend over the past 12 months has been downwards. RSCH is the next highest out of hospital SHMI at 112.
Apart from PRH (82), the in-hospital SHMI is above 100 on all the other sites RSCH (115), SRH (102) WHT (108).

Intervention and Planned Impact

The Clinical Effectiveness Team is piloting a standardised response when the SHMI LCL is above 100 for a diagnostic group or specific hospital site.
This standardised response will be used to review some of the current outliers in head and neck cancer; melanomas of skin; pancreatic and breast cancer.

Risks/Mitigations

No Data

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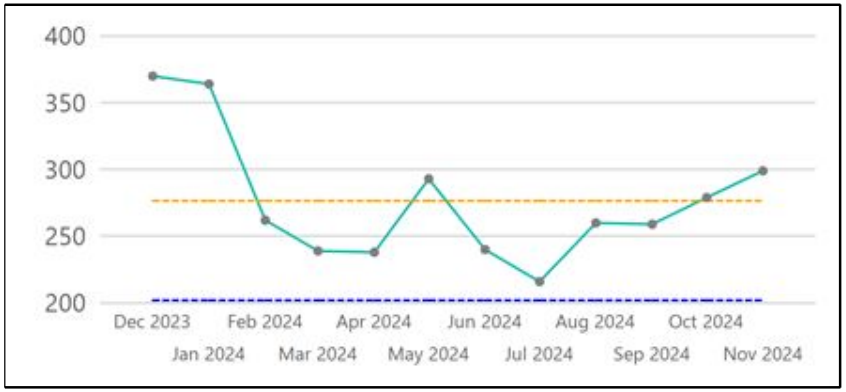
Breakthrough

Metric: Safety - To reduce falls whilst in the care of UHSussex by 30%

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
370	364	262	239	238	293	240	216	260	259	279	299

Overview

The quality True North for harm in our organisation is zero harm to our patients when they are in our care. Harms contribute significantly to poor patient experience, outcomes, and staff experience. Falls are the top contributor in terms of harms across UHSussex.



What the chart tells us

There were 299 falls which is an increase of 20 from (Oct 279); 13 moderate and above falls is an increase of 4 from (Oct 9); 27 near misses reported are consistent with previous month, (Oct 27); 31 patients have repeatedly fallen in month, which is consistent with previous month (Oct 32). Falls Rate per 1,000 bed days November 2024 = 4.73 (4.49 average rolling year). This is below the national bench mark of 6.93 per 1000 bed days

71% of falls in month resulted in no harm to the patient.

Falls during day are higher (55%) than overnight (45%), predominantly between 10:00 and 12:00 hours.
69% of reported falls were unwitnessed, a slight improvement from previous month (77%).
Bay and ward closures due to respiratory and norovirus has potentially contributed to falls.

Intervention and Planned Impact

- Work is being planned to undertake a deep dive into fatal/severe falls to establish potential themes and trends.
- HFC Clinical Link nurse roles are being developed
- The RCP E- Learning Package which focuses on Falls in Hospital has been completed.
- HFC nurses continue to support Divisions
- The FSoC for Falls and Mobility has worked with key stakeholders to develop a combined nursing and medical Post fall Management booklet which is planned to be circulated in January. This document includes updates to improve timeliness of care delivery, medical assessment and management of pain.
- Key stakeholders have been involved in developing a revised Intentional Rounding form which has been piloted at PRH/RSCH.

Risks/Mitigations
The FSoC falls and mobility group has now combined with the trust deconditioning and work programme in development. This will be monitored via the FSoC weekly deep dive and two monthly FSoC patient safety group. The Divisions have been driving up improvement opportunities by focusing on the top themes such as completing falls and bedrail risk assessments and undertaking lying and standing blood pressures. This has enabled the identification of actual / potential issues earlier so that mitigations can be put in place. Patients with infection that need to be isolated can contribute to falls Thematic review of Falls is being undertaken in January and February 2025 Falls roundtable is scheduled for February 2025

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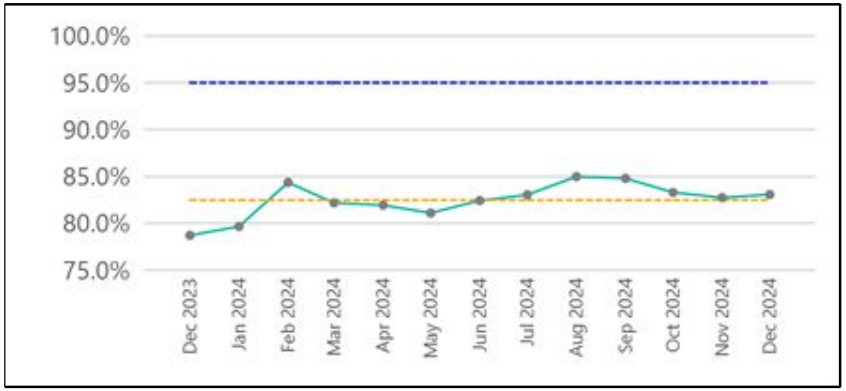
Driver

Metric: Safer Staffing - Average fill rate - care staff (day shifts)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
78.7%	79.7%	84.4%	82.2%	81.9%	81.1%	82.4%	83.0%	85.0%	84.8%	83.3%	82.7%	83.1%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 7.6 in December 24 , despite this the trust remains in the bottom quartile for registered nurses and in quartile 2 for care staff in the data published by the model hospital and the CHPPD data published by NHS England in October 24.



What the chart tells us

The chart shows the fill rate % for care staff for the day shifts each month. Care staff has seen an improving trend in the fill rate for support staff since June 23 when the fill rate was 79% and the vacancies 9.9%. Between April and September 24, the fill rate has gradually improved across UHSussex to 84.8% and the vacancies 7.3%. The ambition is 95%, there has been a slight deterioration in the fill rate in October to December, although the vacancy has not decreased.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. The Safer Nursing Care Tool (SNCT)audit has been completed in November 24 for all inpatient areas including children's and young people ahead of establishment reviews in December and January 25. The Emergency Department (ED) SNCT audit has been completed in December 24 and will be repeated in February 25 ahead of the ED establishment reviews in February 25. The Divisional directors of Nursing (DDoNs) meet the Deputy Chief Nurse(DCN) weekly to monitor and challenge temporary staff usage and all additional shifts authorised have DDON approval and oversight.

Risks/Mitigations
There are currently 7.3% Band 2 care staff vacancies and turnover of 8.1% for support staff across UHSussex. There has been significant work on recruitment to improve the care staff vacancy and we have launched a foundation programme in this financial year to aid HCA retention. There is also high demand for registrants and HCAs with specialist skills to care for patients with mental ill health. 26 enhanced care support workers commenced in post in January to care for patients with mental illness ill health as part of a trust pilot. Rolling recruitment continues for band 2, included targeted campaigns with the Department of Work and pensions (DWP) supporting our local population into employment. The trust has a healthy pipeline of care assistant with 92 HCAs going through the onboarding process, 64 due to start before the end of February 2025.

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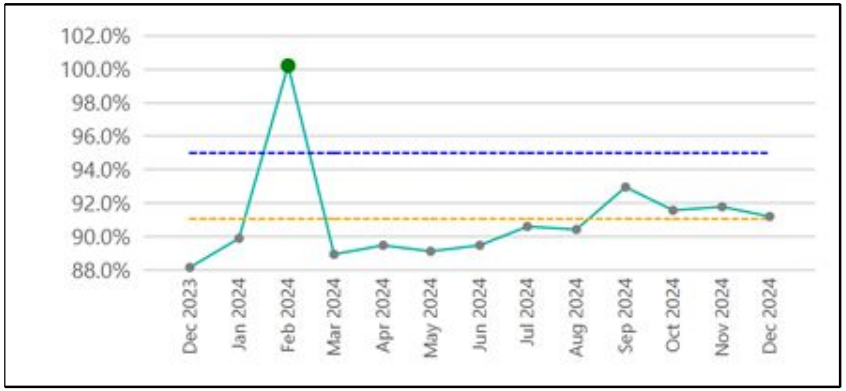
Driver

Metric: Safer Staffing - Average fill rate - care staff (night shifts)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
88.2%	89.9%	100.2%	88.9%	89.5%	89.1%	89.5%	90.6%	90.4%	93.0%	91.6%	91.8%	91.2%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 7.6 in December 24 , despite this the trust remains in the bottom quartile for registered nurses and in quartile 2 for care staff in the data published by the model hospital and the CHPPD data published by NHS England in October 24.



What the chart tells us

The chart shows the fill rate % for care staff for the night shifts each month. The fill rate at Night has been consistently over 90% since July 24, the trust wide fill rate for December is 91.2% Please note the fill rate is better than the day fill rate due to night pay enhancements, the variation has been noted and the work will commence to balance the fill day and night.

Intervention and Planned Impact

The Trust Nursing and Midwifery Steering Group meet monthly to support the Trust in recruiting, deploying, and retaining a nursing and midwifery workforce that is appropriately experienced and qualified to deliver high quality standards of care. The group is also responsible for monitoring and reporting the associated workforce. The Safer Nursing Care Tool (SNCT)audit has been completed in November 24 for all inpatient areas including children's and young people ahead of establishment reviews in December and January 25. The Emergency Department (ED) SNCT audit has been completed in December 24 and repeated in February 25 ahead of the ED establishment reviews in February 25.The Divisional directors of Nursing (DDoNs) meet the Deputy Chief Nurse(DCN) weekly to monitor and challenge temporary staff usage and all additional shifts authorised have DDON approval and oversight.

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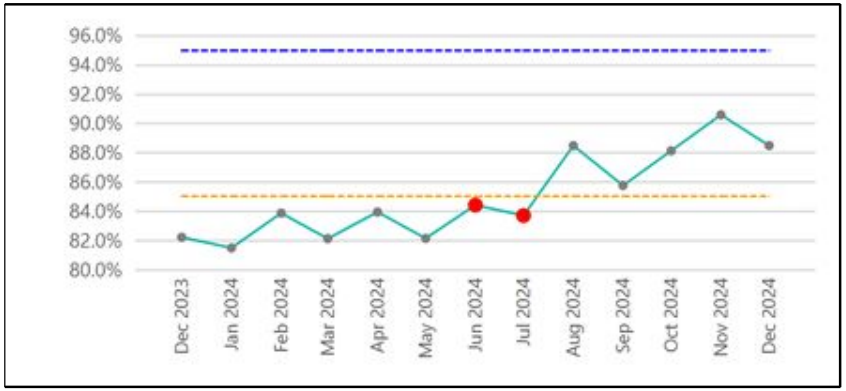
Driver

Metric: Safer Staffing - Average fill rate - registered nurses/ midwives (day shifts)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
82.2%	81.5%	83.9%	82.2%	84.0%	82.2%	84.4%	83.7%	88.5%	85.8%	88.2%	90.6%	88.5%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). Care Hours Per Patient Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 7.6 in December 24 , despite this the trust remains in the bottom quartile for registered nurses and in quartile 2 for care staff in the data published by the model hospital and the CHPPD data published by NHS England in October 24.



What the chart tells us

The chart shows the fill rate % for RN/RM's for the day shifts each month. RN/RM fill rate has seen a gradual increasing trend since March 24 to a peak in November 24 at 90.6%. There was a slight reduction in December to 88.5% trust wide, the ambition is to achieve above 95%. The improvement in fill rate directly correlates with the improving vacancy and retention picture for band 5 staff with the vacancy in December reducing to 11.2% and turnover to 4.3%. Despite the this is requirement for bank and agency due additional capacity above bed base in medicine in Worthing and Chichester, unfunded beds at PRH in Ansty ward and HPP, C10, Neurology and Renal in RSCH. Emergency departments in RSCH and PRH not funded to template, high acuity and additional bed in critical care at RSCH.

Intervention and Planned Impact

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Risks/Mitigations

There is a current vacancy position is 11.2% for Band 5 Registered Nurse/Midwives and turnover is 4.3%.
Rolling recruitment continues for band 5, including targeted campaigns for areas with high vacancy and a focus on targeted recruitment of student nurses who have completed placements at UHSussex.
There are 70 registered nurses in the pipeline with a registration and 31 have a confirmed start date join the workforce between January and March 24. In addition, there are 42 nurses awaiting pin being onboarded, including student nurses and international nurses working as HCAs in other organisations.

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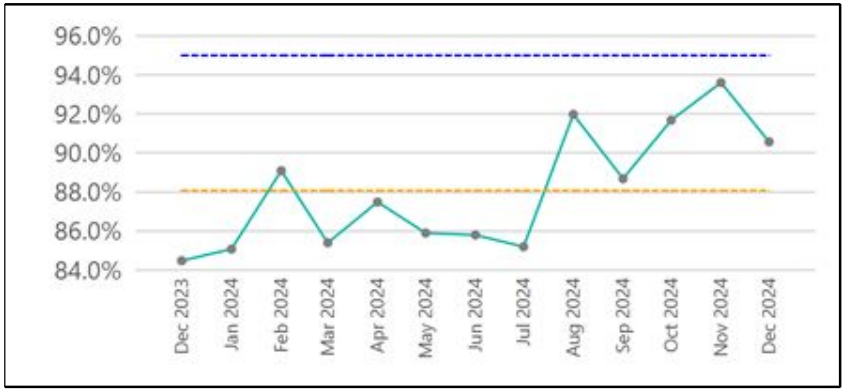
Driver

Metric: Safer Staffing - Average fill rate - registered nurses/ midwives (night shifts)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
84.5%	85.1%	89.1%	85.4%	87.5%	85.9%	85.8%	85.2%	92.0%	88.7%	91.7%	93.6%	90.6%

Overview

Patients have the right to be cared for appropriately by qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution. There is growing evidence which shows that nurse staffing levels make a difference in patient outcomes, patient experience, quality of care, and efficiency of care delivery. (RCN,2011; Griffiths and Balls, 2021) Trusts must ensure they have the right staff with the right skills in the right place (DOH, 2021 Nursing Quality Board). .Care Hours Per Patient Day (CHPPD) trust wide has seen a gradual increase from 7.0 in December 23 to 7.6 in December 24 , despite this the trust remains in the bottom quartile for registered nurses and in quartile 2 for care staff in the data published by the model hospital and the CHPPD data published by NHS England in October 24.



What the chart tells us

RN/RM fill rate ay night has seen a gradual increasing trend since December 23 to a peak in November 93.6%. The higher fill rate at night correlates with the higher cost shifts and the better uptake of temporary staffing to these shifts. There was a slight reduction in December to 90.6% trust wide. The improvement correlates with the improving vacancy and retention for band 5 staff with the vacancy in December reducing 11.2% and turnover to 4.3%. Despite this there has still been a requirement for bank and agency due additional capacity above bed base in medicine in Worthing and Chichester, unfunded beds at PRH in Ansty ward and HPP, C10, Neurology and Renal in RSCH. Emergency departments in RSCH and PRH not funded to template, high acuity and additional bed in critical care at RSCH.

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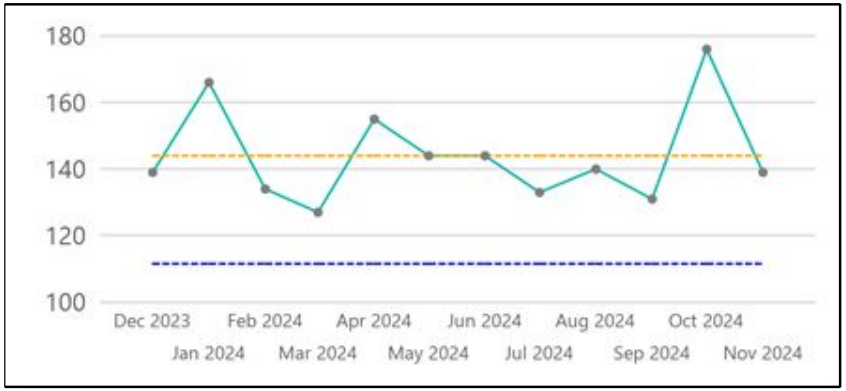
Metric: Safety - Grade 2+ pressure ulcers

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
139	166	134	127	155	144	144	133	140	131	176	139

Overview

Risk factors for developing a hospital-acquired pressure injury include older age, immobility, altered mental condition, urinary or faecal incontinence, hospitalisation for fracture, surgical intervention, reduced appetite and nasogastric tube or intravenous nutrition. Research has shown that pressure injuries are preventable. The strategy for preventing pressure injuries relies on two interdependent domains: pressure injury risk identification and pressure injury risk mitigation.



What the chart tells us

Overall, 139 patients with hospital acquired Category 2 and above pressure ulcers, which is a decrease of 39 when compared to Oct (n=178). There were 78 patients with hospital acquired moisture associated skin damage (Oct 64). PU Rate per 1,000 bed days November 2024 = 2.42 (2.47 average rolling year).

Intervention and Planned Impact

In November it was national “Stop the Pressure” week where the TVN team shared various educational updates and information sharing across the various hospital sites. This had good engagement and support from clinical teams who have updated their educational boards within wards.
A rapid review for Pressure Damage has been developed and the ELR template updated which has been shared through NMAHP and other forums.
The Dressing Formulary has been agreed across the Trust which standardises dressings selection. Waiting for Procurement to operationalise this and arranging training updates from the relevant dressing suppliers.
Categorisation bitesize teaching sessions are being offered to areas that have identified this as a need following incidents which include referral process and reporting of HAPU.
Slide sheets are now consistent across the Trust- and any shearing damage will now be able to be monitored through the rapid review template.

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Risks/Mitigations
There has been a rise in moisture related pressure damage. Moving forward the FSoC pressure damage working group has now combined with the continence group and a programme of work being crafted. There were different PD risk assessments across UHSussex the Purpose T risk assessment for skin assessment has now been standardised across all sites. Next steps are to standardise the intentional rounding chart by March 2025 The Divisions have been driving up improvement opportunities by focusing on the top themes such as completing pressure damage and nutritional risk assessments on time to allow earlier identification of actual / potential issues. This will be monitored via the FSoC weekly deep dive and two monthly FSoC patient safety group Weekly harm free care meeting chaired by the DCN / HON to discuss all category two and above pressure damage to understand key learning points for onward dissemination

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Watch Metrics for Quality

Metric	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Clinical outcomes/effectiveness - Timeliness of observations against targets (NEWS2)	63.7%	64.4%	64.4%	65.4%	66.9%	68.3%	68.5%	69.2%	70.2%	72.0%	73.5%	74.7%	73.1%
HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	18	16	9	20	16	16	18	12	14	24	23	15	25
HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	25	20	20	14	13	21	20	24	18	26	25	16	14
HCAI - Number of hospital attributable Klebsiella species cases (HOHA/COHA)	8	9	4	3	6	11	3	6	9	6	8	6	4
HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)				2	1	1	1		1	0	0	0	0
HCAI - Number of hospital attributable MSSA bacteraemia cases (HOHA/COHA)	9	8	8	11	6	12	6	8	6	8	12	13	13
HCAI - Number of hospital attributable Pseudomonas cases (HOHA/COHA)	4	1	2	4	6	2	5	3	5	1	4	4	3
Safety - % of Deaths with Comfort Obs in Place	73.0%	74.5%	76.7%	67.3%	79.0%	75.2%	70.8%	74.6%	76.6%	77.2%	76.4%	69.8%	72.8%
Safety - Total moderate, severe or death incidents	8	23	62	58	91	87	76	93	89	106	77	97	

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Systems & Partnerships

	Metric	Target
Breakthrough	A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)	11:00
True North	Cancer - To achieve the 62 day standard (All referrals - National standard revised Oct 2023)	70.00%
True North	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	

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Patient First Domain

The Systems & Partnerships True North domain of 'delivering timely, appropriate access to acute care as part of a wider integrated system' is measured through the key national emergency and elective care NHS Constitutional access standards:

- A&E: treatment and admission or discharge within 4 hours;
- Referral To Treatment (RTT) definitive treatment within 18 weeks;
- Cancer: diagnosis and treatment within 62 days
- Diagnostics: investigation undertaken within 6 weeks

Performance remained challenged across each of these areas in Q3 2024/25, although there has been notable improvement in cancer and diagnostics. RTT also saw improvement, however, UHSX remains a national outlier for both the number and the proportion of long waiters. A&E performance deteriorated in Q3, and the Trust was worse than national median.

UHSX remains in Tier 1 as part of the NHSE oversight framework for RTT, cancer and diagnostics. The Trust is in Tier 2 for emergency performance.

65-week waits have continued to improve (although rose slightly in Dec-24) but remains the highest in the country. 78-week waits reduced marginally but remain higher than Mar-24 position. The Trust reported 6 104-week waits. The overall RTT waiting list reduced in Q3, however, a change in reporting for MSK patients led to a small increase in December. Excluding the impact of that change there was continued month-on-month reduction, continuing the trend over the past 15 months with a ~24% reduction during that period.

Cancer performance improved in both 28-day 'faster diagnosis' and 62-day cancer waiting time standards and the trust delivered it's improvement trajectories for these in Nov-24 (latest reported period). The backlog of over 62-day prospective waits increased in December but has improved compared to same period last year.

Diagnostics performance improved in Q3, but seasonal factors drove a small deterioration in Dec-24. There has been notable reduction in 6-week waits in MRI and across endoscopy modalities. The total Diagnostic waiting list and backlog both reduced and the Trust's performance is now close to national median position.

A&E performance (including Minor Injury Units and Walk In Centres) was 63.4% in Dec-24, which was a deterioration compared to both Nov-24 and the same period 12 months average.

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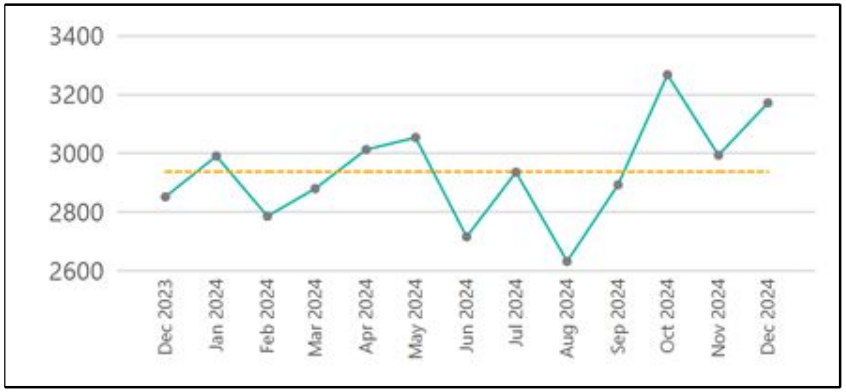
True North

Metric: A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
2852	2991	2786	2880	3013	3054	2716	2936	2632	2893	3268	2994	3172

Overview

12 hr breaches increased across the trust from last month and also from Dec 23. The range across the EDs is varied and reflects the flow through the sites. UHSx for Dec-24: 8.7% of patients remained in ED for more than 12 hrs compared to 8.1% Nov-24 and 8.1% Dec-23.



What the chart tells us

The metric deteriorated in December overall to 8.7% from 8.1% and is variable by site, with 16.5% of patients breaching 12 hrs at RSCH (15.9% last December). Worthing reduced to 6.9% from 7.8% last month - 6.7% last December. PRH increased to 11.5% from 10.9% in the previous month (10.8% Dec-23) and SRH fell to 12.2% from 8.6% (10.2% in Dec-23). Emergency improvement plans are going to be widened to include all divisions which contribute to UEC performance.

Performance in December was challenged by an increase in attendances and also a large number of bays and wards being impacted by flu, norovirus and covid. This results in challenged flow as more difficult to place patients as well as beds being lost due to IPC

Intervention and Planned Impact

To decrease the risk held in ED with high volumes of patients over 12 hrs and the associated link with morbidity, the introduction of continuous flow throughout the day is being managed. This results in less patients being held in ED corridors and more patients moved to the wards where they wait until a patient is discharged or the patient being discharged that day is sat out and the admitted patient placed in the vacated bed space.
The use of the discharge lounge is being tightly managed to ensure more patients move there earlier in the day thereby freeing up space earlier in the wards

Risks/Mitigations

The risk is that the patients are not moved from the wards to the discharge lounge or that they are not discharged early enough in the day.
This is being mitigated by managers of the day liaising with their wards to ensure that the early movement required is achieved. Numbers through teh discharge is being monitored as well as the numbers being moved by the continuous flow model is mapped and maintained through the day.

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True North

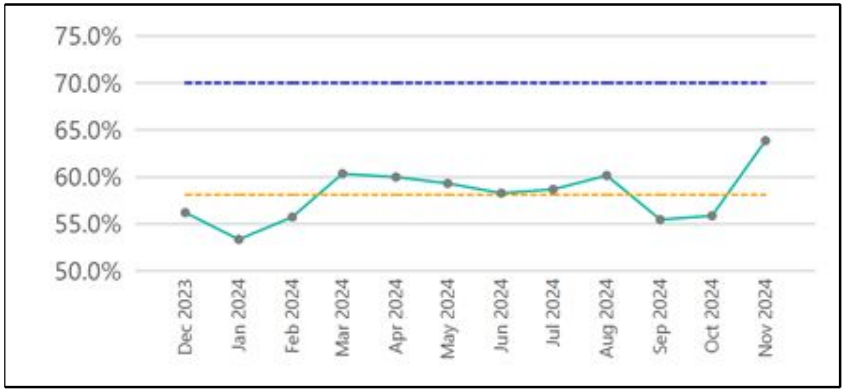
Metric: Cancer - To achieve the 62 day standard
(All referrals - National standard revised Oct 2023)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
56.20%	53.34%	55.72%	60.34%	59.98%	59.31%	58.27%	58.67%	60.15%	55.45%	55.86%	63.86%

Overview

Cancer 62 day performance is a constitutional standard, with a target of 85% of patients to be referred and commence first definitive treatment within 62 days.

Please not that the constitutional standard changed in Oct-23 to include patients from all referral sources, having previously covered only urgent GP referral only.
UHSX has committed to improving performance to 70% by Mar-25, in line with national planning guidance.



What the chart tells us

The chart shows the % of patients who commenced treatment each month within 62 days. Cancer information runs a month in arrears, to allow for collation of shared pathways with tertiary providers and improve the accuracy of reporting.
Nov-24 performance was 63.9%, compared to 55.9% in Oct-24 and national standard of 85%; this was best performance for past 12 months..

Intervention and Planned Impact

The trust has developed recovery plans for each challenged tumour-site. These are being overseen through enhanced governance led by the COO, MD (planned care), and Deputy MD (Cancer) and supported by the Surrey and Sussex Cancer Alliance.

Tumour site plans are focused on improving diagnostic and treatment capacity, shortening the front of the pathway and reducing the backlog. 62-day performance will only materially improve once the backlog has been reduced and sustained at a lower level.
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.
The Trust has been awarded additional financial support by NHS England to recover cancer performance as part of the 'Tier 1' regime.

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Risks/Mitigations
Risks to deliver of the 62-day standard include: Management bandwidth to engage, given scale of challenges in other areas (for example A&E and RTT). This is being mitigated through use of additional PMO and analytical support from Surrey and Sussex Cancer Alliance. Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance and Tier One for extra capacity Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.

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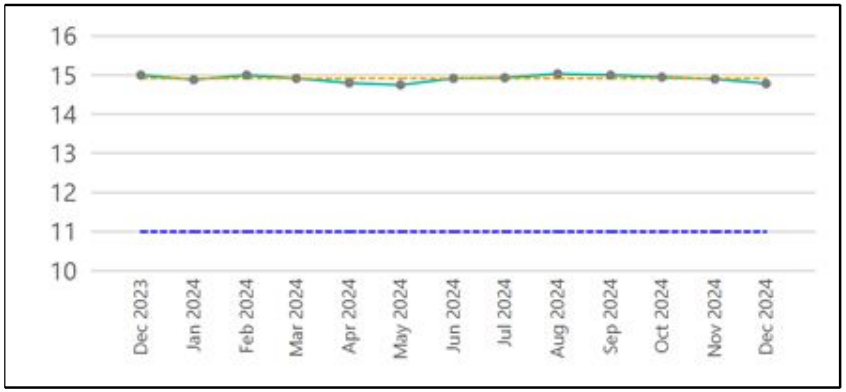
Breakthrough

Metric: A&E and Emergency flow - Hour of discharge median will be 10am to 10.59am (home for lunch) (Trust Level)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
15:00	14:53	15:00	14:55	14:48	14:45	14:55	14:56	15:02	15:00	14:57	14:54	14:47

Overview

There has been very little variation in the MHD most of the year - with changes of around 10 mins and this has fluctuated and we are unable to point a a positive consistent trajectory



What the chart tells us

Length of Stay Dec 23 was 15:00 and Dec 24 there had been a 13 minute improvement to 14.47.
This improvement has not been steady through the year though. There had been positive movement in the beginning part of the year to 14.45 in May which then increased back to 15.00 by Sept.
The Trust is a long way from the target of 11.00 whihc has been set as the MHD

Intervention and Planned Impact

The MHD breakthrough objective continues with emphasis on TTO being completed the day before discharge, discharge dates being set on admission and twice daily board rounds
The work dovetails into the LoS CP with the discharge standards needing to be followed and adhered to in order to improve the discharge pathway the patient is on and ensure all preparation is completed the day before discharge

Risks/Mitigations

The risk is that the second board round does not happen as consultant job plans do not always allow it. However it can be any member of the MDT leading the second round as it is a follow up round to ensure the actions agreed earlier on in the day have been completed/are underway to ensure the patient moves through their pathway as quickly as possible.
TTOs may not be done in a timely way due to the number of outliers at present on our wards. Junior docs need to be allocated time in their day to ensure that the TTOs for the next day are completed.

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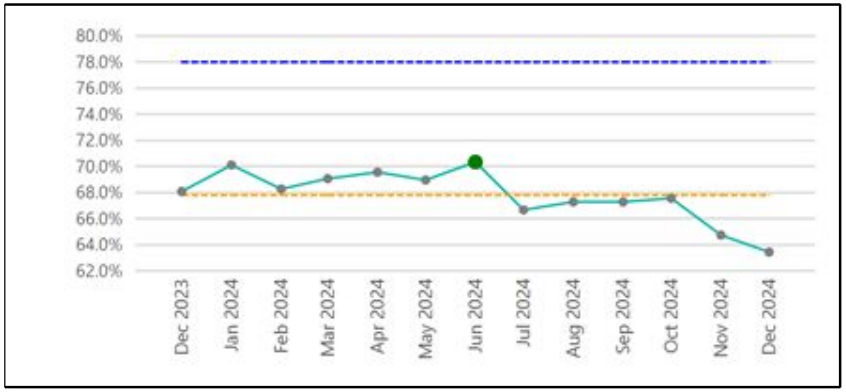
Driver

Metric: A&E and Emergency flow - % treated and admitted/discharged within 4 hours

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
68.1%	70.1%	68.3%	69.1%	69.6%	69.0%	70.3%	66.7%	67.3%	67.3%	67.6%	64.7%	63.4%

Overview

Performance overall in December has worsened since from a more positive position of 73% in October 24 by 1.1%. By site, the 4 large sites saw a reduction in performance whilst RACH improved significantly (+11.2% to 91.0%). Performance for UHSx was the same as Dec 24 with an increased number of attendances
For context UHSx was ranked 76 out of 123 providers in Dec.



What the chart tells us

The performance against the 4 Hr target has worsened to 66.6% from 67.5% in Nov (this is for UHSx as a whole)

By site, the 4 large sites saw a reduction in performance:

RSCH: -3.2% , PRH -3.5%

SRH: -2.7%, Worthing by -0.8%.

Performance at RACH improved by +11.2% (91.0%)

There has been a steady decrease in performance all year with a worsened decrease in the winter months

Intervention and Planned Impact

Weekly UEC oversight meetings are held with the medicine division and this includes the Chief of Service. This looks at the immediate issues which need addressing and any quick actions which can be implemented to improve performance and patient experience.
The Site based UEC improvement groups continue with longer term improvements being worked through and supported by the Trust Improvement Team. There are monthly meetings held with the HDs to check progress and establish if there are any escalations required.
The impact is quick PDSA cycles as well as longer term sustainable changes made to processes.

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Risks/Mitigations
The risk is that the internal interventions are not enough to meet the demand through ED and the winter pressures seen during the last Quarter of this year. The increase in winter virus' and sickness impacts staff as well as our patients. There is work going on in the community services to manage increased admission avoidance to try and limit the numbers presenting at the front door of ED. We are increasing SDEC services / pathways where possible to divert patients to these services. There was a roll out of the flu and covid vaccination programme for all staff.

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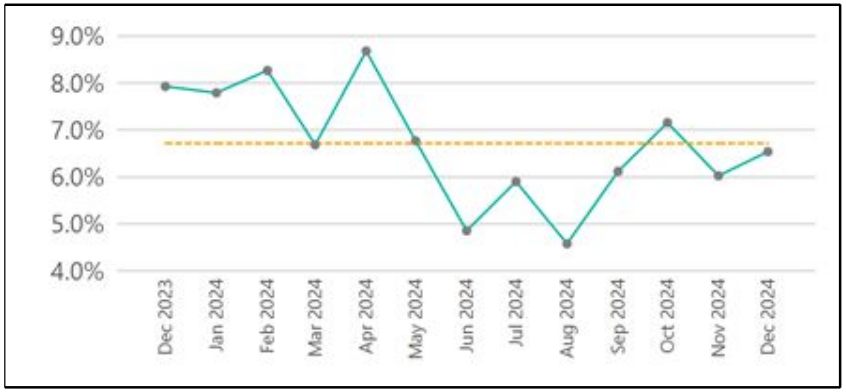
Driver

Metric: A&E and Emergency flow - Ambulance Handovers > 60 minutes

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
7.9%	7.8%	8.3%	6.7%	8.7%	6.8%	4.9%	5.9%	4.6%	6.1%	7.2%	6.0%	6.5%

Overview

UHSx continues to struggle with 60 min ambulance handovers but the problem is worse at RSCH and PRH than at WGH and SRH.
The main issue used to be with RSCH but PRH is also experiencing some delays in this category as well which has been driven by their 12 hr delays and also the use of the corridor in ED



What the chart tells us

Despite the 60 min handover position being much higher than the zero tolerance target, UHSx is in a better position than Dec 23 when 11.3% if ambulance arrivals at RSCH/PRH and 5.3% of ambulance arrivals at SRH/WGH waited for more than 60mins Dec 24 saw the figures of 10.9% and 3.3% respectively

Intervention and Planned Impact

The same action for 12 hrs in ED will impact the flow in department which will have a knock on effect for 60 mins handover breaches.
There is a greater awareness of the need to not hold ambulances for long periods of time which means that the departments are more mindful of the long waits.
The working relationship with SECAMB has improved to ensure improved communications especially through periods of pressure

Risks/Mitigations

The risk is that the department and corridors become overcrowded with patients due to ambulances dropping off and handover happening regardless of the department capacity..
Continuous flow and increased use of discharge lounge should alleviate teh pressure within the department and allowing handover space for teh ambualnces

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Driver

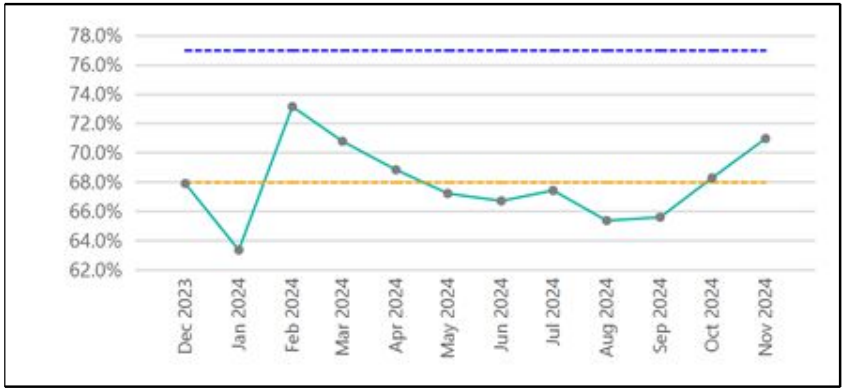
Metric: Cancer - 28 day faster diagnosis standard

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
67.92%	63.37%	73.17%	70.80%	68.85%	67.24%	66.73%	67.44%	65.38%	65.61%	68.29%	70.99%

Overview

The 28 day faster diagnosis standard (introduced Jul-19) is an important target for patient experience and forms part of expedient cancer pathways. The national standard sets a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred urgently for investigation of cancer (including those with breast symptoms) and from NHS cancer screening, with a 77% target for 2024/25.

UHSX has committed to achievement of 77% by March 2025, in line with national planning guidance ask.



What the chart tells us

FDS performance improved in Nov-24 to 71.0% against the 77% target (from 68.3% in Oct-24), and is above the 12-month average.

Intervention and Planned Impact

The **FDS performance** has been most significantly impacted by Breast, **Colorectal, Gynaecology, Skin, UGI and Urology**.

•**Breast** performance is mainly affected by triple assessment capacity at the front of the pathway.
•**Colorectal** performance is mainly affected by vacant nursing posts managing the assessment and onward referral for first diagnostic leading to batches of referrals hitting Endoscopy in particular, unable to perform scopes in pace with batched referral demand.
•**Gynaecology** performance is mainly affected by the shortage of sonographer USS capacity and hyst delays.
•**Haematology** performance is mainly affected by late referrals across from other tumour sites.
•**UGI** performance is currently affected by delayed endoscopic and radiological diagnostics.
•**Urology** performance is mainly affected by delays to biopsy and OP capacity.

Tumour site improvement plans to address these issues are in place,

England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress, and support with recovery including £1.1m of schemes to improve cancer wait times.

Risks/Mitigations

Risks to deliver of the 28 day FDS include:
Increased demand - mitigated by working with primary care colleagues to clarify referral pathways in high demand areas - for example, established a post menopausal bleeding on HRT pathway.
Diagnostic capacity challenge - mitigated by securing funding from the cancer alliance for extra capacity
Navigator roles to ensure pathways are closely observed - alliance funding for high-risk pathways now secured so that detailed navigator overview is in place.

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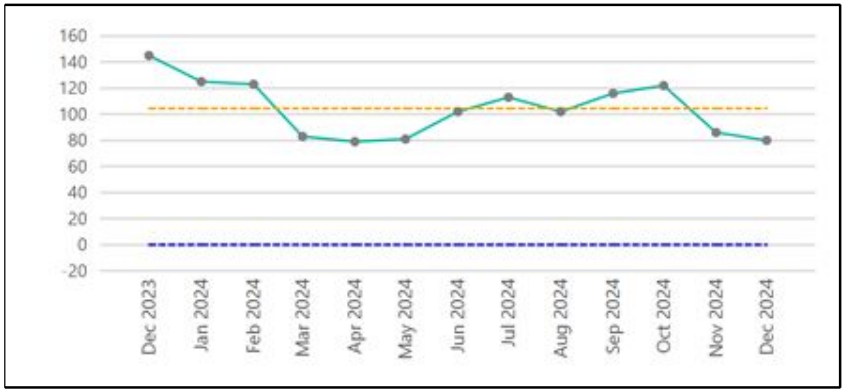
Driver

Metric: Cancer - Number of patients waiting over 104 days for treatment

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
145	125	123	83	79	81	102	113	102	116	122	86	80

Overview

Cancer Waiting Times operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons.
A small proportion of patients will have a recorded waiting time of more than 104 days, usually for these reasons (i.e. 6 weeks beyond a breach of the 62 day standard).
Patients with a long waiting time need both proactive and retrospective management so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice. Equally, providers should have effective processes in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a harm event for the delayed patient concerned.



What the chart tells us

There has been a decrease in over 104-day waits from 86 in Oct-24 to 80 in Dec-24; this is second lowest for past 12 months.

Intervention and Planned Impact

The trust has developed recovery plans for each challenged tumour-site. These are being overseen through enhanced governance led by the COO, MD (planned care), and Deputy MD (Cancer) and supported by the Surrey and Sussex Cancer Alliance.

NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.

The Trust has been awarded additional financial support to help contribute to recovery of the cancer performance position as part of NHS England's 'Tier 1' regime.

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Risks/Mitigations
Patient choice and complexity pose the greatest risk to 104-day waits. These should be mitigated through proactive forward-planning and effective communication. Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways.

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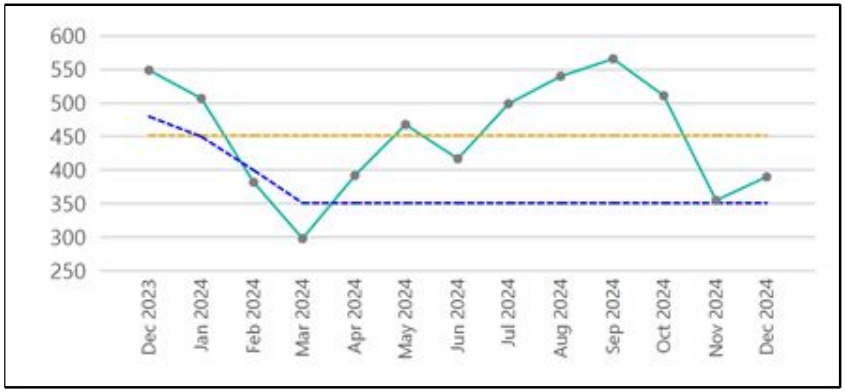
Driver

Metric: Cancer - Number of patients waiting over 62 days for treatment

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
549	507	382	298	392	468	417	499	540	566	511	355	390

Overview

The NHS operating framework 24/25 requires Trusts to improve 62-day performance to 70% by Mar-25. To deliver this, UHSX has to maintain a backlog below it's 'fair share' target of 351.
The Trust is required to reduce and sustain the 62-day backlog at or below 351 patients as a result of being placed in Tier 1 by NHS England.



What the chart tells us

62-day prospective waits increased from 355 to 390 in Dec-24,reflecting impact of Christmas and festive period on activity and patient choice.

Intervention and Planned Impact

To return to fair share target backlog, 62-day prospective waits need to be reduced in skin, lower GI and gynae.
Tumour site recovery plans have been agreed for each of these, and form part of our H2 cancer recovery plan. This is being overseen by COO, and supported by Surrey and Sussex Cancer Alliance (who are providing PMO capacity as well as pathway analysis to drive improvement).
NHS England has placed the Trust into its 'Tier 1' regime due to challenges with cancer waits. This includes fortnightly oversight meetings with CEO to monitor progress.

The Trust was awarded additional financial support to help recovery cancer performance as part of the 'Tier 1' regime.

Risks/Mitigations

Management bandwidth to engage, given scale of challenges in other areas (for example A&E and RTT). This is being mitigated through use of additional PMO and analytical support from Surrey and Sussex Cancer Alliance.

Diagnostic capacity is a risk for the Trust as patients progress through their cancer pathways, and with similar pressure at this stage of treatment from the RTT recovery programme and emergency pathways. This has been mitigated through additional Tier One funding for diagnostic capacity.

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Driver

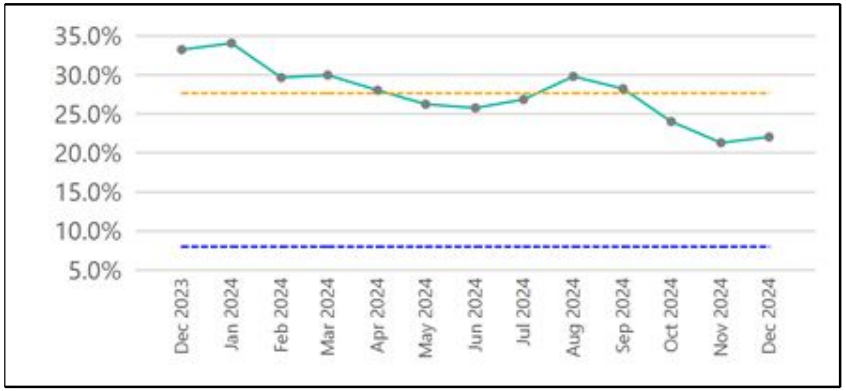
Metric: Diagnostics - % Breaching 6 week target (DM01 modalities)

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
33.2%	34.1%	29.7%	30.0%	28.0%	26.3%	25.8%	26.9%	29.8%	28.2%	24.0%	21.3%	22.1%

Overview

Diagnostics are an important element of elective care for patient care and are an essential part of decision-making towards definitive treatment. Performance is measured using the 'DM01' standard, which tracks waits across 15 diagnostic tests, ranging from imaging modalities, to physiological measurement, to endoscopic investigations.

The 2024/5 operating framework includes ambition to achieve no more than 8% of over 6-week waits by end March-25.



What the chart tells us

UHSX achieved 22.1% in Dec-24 against the DM01 standard, and slight deterioration compared to Nov-24 (21.3%) reflecting impact of Christmas and festive period; reduced activity impacted backlog (numerator), while reduced referrals impacted total waiting list (denominator).

Intervention and Planned Impact

Targeted recovery plans - with support from ICB - have been agreed for each of the most challenged modalities.
Delivery of plans being overseen weekly though planned care governance and oversight meeting.
Director of Performance overseeing review of data quality and reporting practices, to ensure in line with national guidance.

Risks/Mitigations

There remain risks around the amount of additional diagnostic capacity required to support emergency, cancer and RTT recovery.
Capacity for cardiac imaging and enhanced sedation endoscopy is limited, and reliant on fragile workforce.

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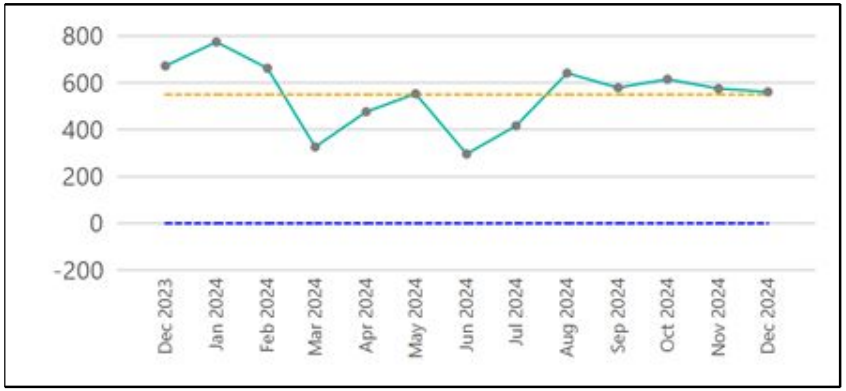
Driver

Metric: Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
672	774	662	326	476	553	296	416	641	579	615	575	561

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The national operating framework required the elimination of 78 week waits by the end March-23. The 2024/25 target is to go further and look to reduce the number of 65 week waits to zero by the end Sep-24. Due to challenges in the achievement of these targets, the Trust was placed in Tier 1 by NHSE in Sep-23, with enhanced CEO review with NHSE Executive on a fortnightly basis to oversee recovery. UHSX agreed a Mar-24 target of 298 78-week waits through the Tier 1 process. UHSX has committed to eliminating waits of 78 weeks in H2 2024/25.



What the chart tells us

The chart shows the number of patients who are waiting over 78 weeks at the end of each month. At the end of Dec-24 there were 559 patients waiting over 78 weeks, an improvement from 575 in Nov-24.

Intervention and Planned Impact

Divisions have developed recovery plans by specialty to target reduction of 65-week waits (which includes all 78-week waits). These are tracked closely on a weekly cycle to ensure adherence to plan, with additional actions if the recovery is off track.
The Trust has enhanced governance with thrice weekly oversight by COO and MD (planned care and cancer). There is weekly oversight of system capacity and how this is being used to support improvement in UHSX, chaired by MD. The Trust also has fortnightly meetings with CEO and NHS executive to oversee progress as part of 'Tier 1' regime.
These interventions will continue as the Trust works to deliver zero 78-week waits.

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Risks/Mitigations
PTL shape and growth: The growth in the PTL since the pandemic means there is an increased number of patients in the 78ww risk cohort, and the Trust has to treat an increased number of patients to avoid increasing numbers of 78ww. There are some highly complex pathways and specialist capacity constraints, which have created risk in minimising 78 week numbers. Increases in urgent or suspected cancer referral demand (which take precedence in terms of clinical priority) also constrain residual routine waiters capacity. There was a 9% growth in cancer referrals in 2023 v 2022.

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Driver

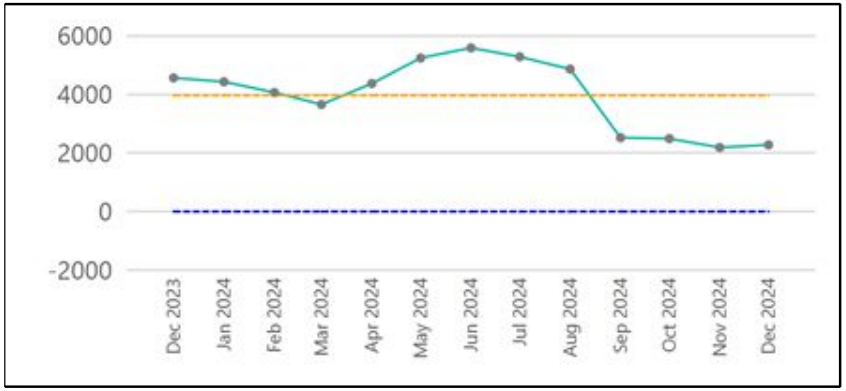
Metric: RTT Elective care - >=65 Weeks

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
4566	4434	4067	3658	4374	5245	5592	5288	4866	2525	2492	2189	2278

Overview

Elective waiting times are a key constitutional target. Elective Waiting times materially increased as a result of the covid pandemic. The 2024/25 national target is to reduce the number of 65-week waits to zero by the end Sep-24. UHSX did not acheive this, and has agreed an H2 plan to reach zero 65-week waits by Mar-25.

Due to challenges with 65-week wait performance, the Trust has been placed in Tier 1 level support by NHSE.



What the chart tells us

The number of patients waiting over 65 weeks increased from 2,189 in Nov-24 to 2,257 in Dec-24. This is the second lowest total for over two years.

Intervention and Planned Impact
UHSX has, along with ESHT & QVH, jointly agreed a plan to reach zero for H2. This is based on: 1. Opening forecast of ~6100 on 'do nothing more' basis (Forecast as of 29/09) 2. UHSX increasing activity further (both through productivity & WLI/insourcing) to close by further ~2,900; UHSX is being supported by the national Getting It Right First Time team over the next 6 months to achieve this. 3. ESHT and QVH using their capacity to treat 2,081 and 550 UHSX patients from the cohort respectively. 4. Independent Sector capacity being used to close the gap to zero. UHSX Specialty-level plans for H2 have been agreed, and are currently subject to check and challenge. Patients have now been transferred to ESHT & QVH, and UHSX is focused on delivering internal plans to reach zero. UHSX CEO is lead for this plan across Sussex. UHSX MD is operationally leading delivery on behalf of the three NHS providers. Sussex system support is being overseen through weekly system capacity meeting, chaired by MD, with weekly oversight from COOs. Tier One oversight for RTT will now be of the whole Sussex System and not just UHSX.
Risks/Mitigations
Urgent and emergency pressures have exacerbated risk associated with 65 week waits over the past 12 months. Increases in urgent or cancer demand (which take precedence in terms of clinical priority order) also constrain capacity for routine waiters capacity. UHSX is reliant on system working and capacity being available at other providers (both independent sector and NHS) in order to deliver this objective.

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Driver

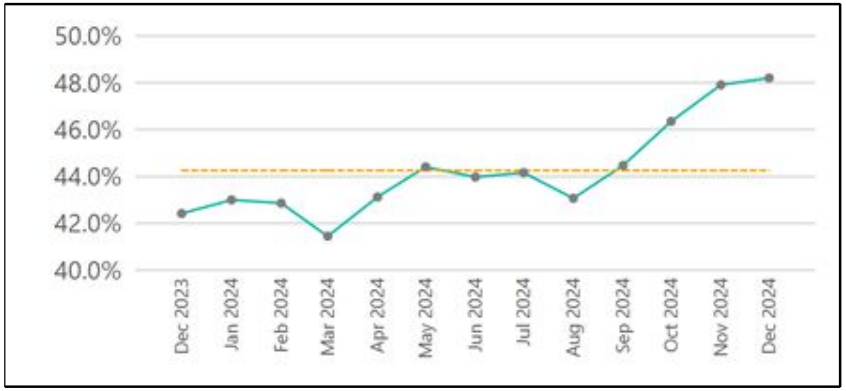
Metric: RTT Elective care - 18 Week Performance

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
42.42%	43.00%	42.86%	41.45%	43.12%	44.41%	43.98%	44.16%	43.07%	44.47%	46.35%	47.91%	48.20%

Overview

Under Referral to Treatment (RTT) incomplete pathways constitutional target, 92% of patients should be waiting under 18 weeks to commence first definitive treatment following GP or consultant referral. Incomplete performance was affected by Covid-19 pandemic due to a reduction in capacity in order to treat covid patients, which led to growth in the RTT backlog and total waiting list.

Reducing long waiters (104+,78+ and 65+ week waits) had superseded the 18 week target as acute Trusts look to tackle the very longest waits as part of staged recovery to reduced waits for elective care. However, this is expected to be the primary focus of elective recovery in 2025/26.



What the chart tells us

The chart shows the % of incomplete pathways that have waited less than 18 weeks to start definitive treatment. This had shown steady decline following Covid impact on planned care activity and waits, and as demand (in terms of clock starting events) has outstripped supply (clock stops/removals for other reasons from the waiting list). However, the Trust's performance is improving again as the total waiting list come down.

Performance was 48.2% in Dec-24, an improvement on Nov-24 (47.9%) and the best performance in over 12 months.

Intervention and Planned Impact
Key actions include: 1. Increasing activity delivered, through: • improved productivity and pathway redesign. For example reducing unnecessary follow ups by increasing use of Straight to Test pathways and PIFU (Patient Initiated Follow Up) • Increased weekend working • Increased use of independent sector • Mutual aid within Trust sites, across Sussex ICB catchment and where possible utilising the Digital Mutual Aid System (DMAS) to seek additional capacity support from beyond the Sussex System 2. Improved waiting list management, with refreshed standardised RTT meetings with operational teams to ensure access policy rules are followed and applied, ensure patients are booked in turn, and ensuring outcomes are captured on the information systems. 3.Enhanced planned care oversight and governance structure with divisional leadership led by MD (planned care) and Director of Performance, with divisions held accountable for improvement focused on all stages of treatment not just longest waits 4. Central validation of pathways over 12 weeks and continued DQ process re waiting list reporting, supported by technological transformation (including robotic process automation)
Risks/Mitigations
There are also some highly complex pathways, and specialist capacity constraints (eg in neurosurgery/spinal care), which have created risk in minimising longest waits. Increases in urgent or cancer demand, which take precedence in terms of clinical priority order can also constrain residual routine waiters capacity. Financial constraints limit the amount of activity that can be delivered outside of plain time.

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Watch Metrics for Systems & Partnerships

Metric	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
A&E and Emergency flow - % Patients with a 21+ day length of stay	8.4%	9.2%	9.0%	8.2%	9.0%	8.4%	8.3%	8.8%	8.1%	8.2%	8.3%	8.0%	8.6%
A&E and Emergency flow - A&E 4 Hour Breaches	11285	10592	10885	11690	10737	11882	10667	10657	9987	9912	10368	11213	11511
A&E and Emergency flow - A&E Attendances	35356	35435	34305	37790	35274	38278	35964	31974	30525	30296	31961	31801	31483
A&E and Emergency flow - Ambulance Handovers	7733	7933	7193	7697	7303	7556	7278	7380	7444	7387	7719	7681	7643
A&E and Emergency flow - Ambulance Handovers - % Under 15 mins	49.8%	52.0%	52.4%	52.9%	49.1%	52.8%	54.6%	51.1%	55.2%	49.4%	47.7%	48.2%	46.0%
A&E and Emergency flow - Average LOS (Excl LOS 0)	7.4	7.9	7.8	7.2	7.7	7.7	7.6	7.8	7.5	7.6	7.3	7.2	7.7
A&E and Emergency flow - Bed Occupancy	1751	1799	1799	1816	1820	1819	1799	1782	1765	1801	1818	1836	1791
A&E and Emergency flow - Emergency Admissions > 1 LOS	5796	5704	5315	5830	5475	5632	5426	5479	5477	5491	5813	5704	5686
A&E and Emergency flow - Mean Waiting Time	338	337	336	325	345	339	315	325	310	329	348	353	362
A&E and Emergency flow - Time to treatment in ED (Median time to treatment mins)	69	68	71	69	63	72	62	70	67	68	64	67	94
A&E and Emergency flow - Time to Triage in ED - % seen within 15 mins	58.9%	60.9%	60.1%	59.9%	63.5%	60.2%	64.6%	62.5%	66.7%	62.1%	62.1%	61.2%	61.2%
Cancer - Two week rule performance	72.0%	69.5%	74.2%	74.1%	67.5%	63.2%	58.8%	66.2%	62.8%	67.3%	72.6%	70.8%	
Diagnostics - 6 week backlog	6829	7219	6427	6491	6036	5458	5331	5481	6044	5645	4895	4118	4135
Diagnostics - Activity	31927	48976	35138	35813	37418	38711	38494	39960	35950	37660	41063	41707	36485
Diagnostics - Waiting List size	19436	19874	20448	20320	20518	19712	19459	19127	19095	18688	19130	18285	17861
Elective care - Activity compared to 2019/20	101.6%	95.6%	96.2%	142.4%	114.5%	116.3%	116.5%	105.8%	106.9%	105.7%	112.1%	110.4%	113.2%
RTT Elective care - >= 52 Weeks	13673	13790	14218	15824	16480	16941	16157	15052	14168	10976	9965	9200	8278
RTT Elective care - >104 Weeks (NHSi Criteria)	4	3	4	0	4	4	4	4	2	4	6	6	6
RTT Elective care - Clock Starts	17246	22556	21484	19448	20563	21290	19011	20716	17698	17468	20540	18977	17157
RTT Elective care - Clock Stops	18437	22931	21460	19925	21765	22277	23470	24053	20976	22814	25072	23236	19764
RTT Elective care - Waiting list size	143841	142481	141662	141173	142917	141517	136410	133732	130232	123868	119791	117899	121127

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Research & Innovation

	Metric	Target
True North	Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies	35

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Patient First Domain
Data for Quarter 3 of 2024-25 for Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 48th putting it outside of the top 20% of recruiting Acute Trusts over the past 12 months. The breakthrough objective of increasing recruitment by 10% year on year will not be achieved in 2024/25. The target annual target of 8328 has been artificially inflated due to the anomaly in recruitment figures for 2023/24. Over 3000 patients were recruited to three studies in 2023/4, one of which the GB3 study in maternal health recruited over 2000 patients. There are less large recruiting studies available to participate in on the NIHR portfolio at present for 2024/25. Unless the landscape changes the breakthrough objective will not be achieved. Through divisional research growth plans, the Trust is focusing upon increasing the number of open interventional studies and commercially sponsored interventional studies this year as a driver for increasing patient treatment access and options.

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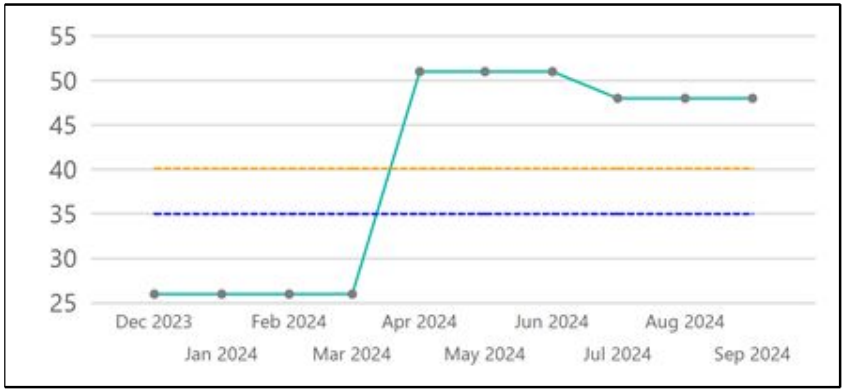
True North

Metric: Within 3 years to be in the top 20 Acute Trusts nationally for patients recruited into portfolio studies

Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24
26	26	26	26	51	51	51	48	48	48

Overview

Research and Innovation drive continuous quality improvement in healthcare but very few staff and patients (1.15 % contribution of national recruitment 2023/24) participate in high quality studies. Participating in research improves patients' satisfaction with clinical care and patients are missing out on this benefit. Higher numbers of quality R&I studies results in better treatments, as well as improved diagnosis, prevention, care and quality of life for our patients and their families.



What the chart tells us

This chart shows shows the 12-month rolling Acute Trust ranking in terms of total recruitment to studies on the NIHR portfolio. The Trust currently stands at 48th putting it outside the top 20% of recruiting Acute Trusts over the past 12 months.

Intervention and Planned Impact

The Trust is developing research and innovation in line with the R&I Strategy.

- We have appointed Divisional Research Directors to support the embedding of research. These roles are helping to promote research in the division through divisional targeted research growth plans.
- Prioritised work is underway to secure estates for the reprovision of the Clinical Research Facility on RSCH site which is essential to the growth in delivery of commercial clinical research.
- The Trust has been selected to host a new NIHR Commercial Research Delivery Centre (CDRC), this will be a Centre of excellence, offering additional commercial research delivery capacity to existing health and care organisations in Sussex. CRDCs will accelerate the delivery of commercial clinical research for the benefit of the health and wealth of the nation
- R&I strategic workstreams are also developing research communication and engagement approaches, research training and education and a programme supporting UHSx research groups and clinical academic career opportunities.

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Risks/Mitigations
It will be key that the UHS Future 2020 strategy reflects the strategic potential of R&I to drive transformations of services and care at UH Sussex. Securing estates for the reprovision of the Clinical Research Facility to a high quality and accreditable standard is the key risk to delivering the Trusts R&I ambition. Existing clinical research facilities are not adequate to support the breath and scale of trust wide participation in research needed to achieve our strategic ambition. This is in the estates master planning process and under Executive discussion – no final plan has been secured at this stage. Workforce and service department capacity to deliver research is also a risk to the delivery of the Trust's research ambition – detailed work with Divisional Directors for Research will help to better clarify the risks and mitigations for each division and support services in Q4. Job planning guidance for research PAs has been agreed and disseminated. A lack of integration of UH Sussex Research and Innovation with wider Sussex health and care systems and universities is also a risk to the delivery of our R&I Ambition. We must continue to drive the success of the Sussex Health and Care Research Partnership working with partners across the Integrated Care System and academic partners to build research which addresses the needs of our population and patients and develops our future research leaders, investing in shared infrastructure such as the Clinical Trials Unit, Training Hub, and Joint Clinical Research Office.

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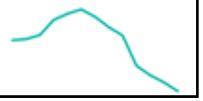
Watch Metrics for

Metric

Oversight Metrics				
Patient First Domain	Metric	Value	Target	Trend
People	Staff Engagement - To be within the top quartile of acute Trusts for the National staff engagement score	6.32	7.06	
Sustainability	Financial Stability - Variance from breakeven plan YTD	-15,090k	0k	
Quality	Summary Hospital-level Mortality Indicator (SHMI) (rolling 12M)	103.8	100.0	
Quality	HCAI - Number of hospital attributable MRSA cases (HOHA/COHA)	0	0	
Quality	HCAI - Number of hospital attributable C.diff cases (HOHA/COHA)	25	2	
Quality	HCAI - Number of hospital attributable E.coli cases (HOHA/COHA)	14	4	
Quality	Safety - Reduction of 5% in preventable harm - UHSx approved	581		
Systems & Partnerships	Cancer - 28 day faster diagnosis standard	70.99%	77.00%	
Systems & Partnerships	RTT Elective care - >= 52 Weeks	8278	11796	

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Systems & Partnerships	Planned care - By March 2023, no patient is waiting more than 78 weeks for treatment.	561	0	
Systems & Partnerships	RTT Elective care - >=65 Weeks	2278	0	
Systems & Partnerships	RTT Elective care - >104 Weeks (NHSi Criteria)	6	0	
Systems & Partnerships	Cancer - Number of patients waiting over 62 days for treatment	390	480	
Systems & Partnerships	A&E and Emergency flow - No patients to exceed a 12 hour wait in our emergency departments	3172		

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Oversight Metric Summary

Current segmentation

The Trust remains in Segment 3 of the National Oversight Framework (NOF) and continues to engage with NHS England and the ICB through their formal oversight processes.
The lead for the oversight of the Trust's performance remains with the ICB and the Trust through quarterly meeting provides assurance on its delivery of its annual plan.

Drivers of the segmentation

During Q3 the Trust has continued to focus on Emergency Care, Cancer and Planned Care delivery. The Trust remains within Tier 1 oversight for Cancer and Planned Care performance and is in Tier 2 oversight for Emergency Care performance seeing enhanced performance oversight continue with NHS E. The Trust whilst meeting its planned care performance plan did not achieve zero patients waiting over 65 weeks and in respect of emergency care performance the Trust has not made the performance gains it expected to with the quarter being challenging.
The Trust's financial plan continues to contain significant risk to its delivery and the Trust's underlying run rate is adverse to the submitted annual plan, and whilst the Trust has been focusing on actions to improve its position across the second half of the year (H2) the delivery of the original plan will not be achieved. The Trust is engaging with both the ICB and NHS E about its most likely out turn position.
The Trust's Single Improvement Plan includes details of the specific improvement plans which when delivered will satisfy the undertakings which the Trust entered into with NHS England. The monitoring of the delivery of these improvements is overseen by a dedicated executive led steering group and NED chaired Board Committee as well as progress being reporting routinely to the ICB and NHSE
The Board Assurance Framework reflects the continuing level of elevated risk across the Trust's strategic objectives and whilst shows for a small number of the Trust 10 Strategic risks marginal reduction will be achieved across quarter 4, the year end target scores will not be achieved for around half of Trust's strategic risks within the domains of people, quality, research and innovation and finance.

Implications of this segmentation

Segment 3 allows the Trust to have access to external advice and support which has included support to aid with the improvement of UEC performance and support for increased capacity and capability to address the Trust's cultural improvement work within the Single Improvement Plan.

Actions being taken to move from segment 3

The Trust continues to progress the delivery of the Single Improvement Plan, as noted above assured through the dedicate Single Improvement Plan Committee Whilst this overall improvement plan captures the actions taken in respect of the specific concerns highlighted by the CQC, there delivery is complementary assured by the Patient and Quality Committee. The Undertakings in respect of operational performance and finance are assured by the Finance and Performance Committee and are also reported through the national Tiering meetings with NHS England (in respect of urgent and emergency, planned and cancer care). The People and Culture Committee assures the delivery of the plans that will satisfy the Undertakings in relation to people.
Given the elevated degree of risk the Trust does not expect to exit segment 3 in 2024/25 but continues with the deliver of its Single Improvement Plan and reporting to the ICB and NHSE on all aspects of this plan and its financial and operational performance. These actions as delivered across 2025/26 will offer the opportunity to exit segment 3.

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Agenda Item:	9.	**Meeting:**	Trust Board in Public	**Meeting Date:**	06 February 2025
Report Title:	Single Improvement Plan				
Sponsoring Executive Director:	Professor Catherine (Katie) Urch, Chief Medical Officer				
Author(s):	Nicole Chavaudra, Single Improvement Plan SRO				
Report previously considered by and date:	Not applicable				

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	N/A
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	Yes / N/A	Staff confidentiality	Yes / N/A
Patient confidentiality	Yes / N/A	Other exceptional circumstances	Yes / N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in overall poorer patient experience and potential for adverse reputational impact.
Sustainability	Yes	2.1 We fail to deliver the in-year financial plan; alongside the requirement to return to a breakeven run-rate by M12 2025/26 and secure medium-term sustainability
People	Yes	3.2 We will not achieve our strategic aims and realise the benefits of merger, including improving patient safety and recruiting and retaining talent unless we take action to; develop a clear strategy, invest in and prioritise focussed work on culture change from 'Board to Ward' including developing our leaders to be engaging, inclusive and empathetic, aligning sub-cultures and addressing cultural gaps and reducing cultural variation
Quality	Yes	4.1 We are unable to demonstrate compliance with regulatory and quality standards 4.2 We are unable to deliver any safe and harm free care
Systems and Partnerships	Yes	5.2 We are unable to deliver and demonstrate consistent compliance with the 24/25 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and the Trust's reputation and financial position.
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement
R
Communication and Consultation:
This report has been shared with the Single Improvement Plan Committee.
Executive Summary:

1. **Introduction and context**

Approved in June 2024, the Single Improvement Plan (SIP) is a fixed term plan, with associated governance, developed in response to the required undertakings. Whilst it does not represent the totality of the Trust's improvement efforts, it provides a cohesive response to the critical, current issues and priorities for the trust to meet the expectations of our patients, staff and regulators over coming months. This has been developed over a period of nine months, in collaboration with ICB and NHSE, who have confirmed that the plan meets their expectations. The plan will inform the new Trust Strategy on which a programme of engagement – The Big Conversation – is now underway, to establish our roadmap for the years to come.

The plan, which has evolved since its approval, includes the following domains: CQC; quality improvement; culture; surgery; planned care; cancer; urgent and emergency care; equality, diversity and inclusion (EDI); specialised services; maternity; well-led; and finance. These are overseen by the SIP committee.

A process of alignment of the SIP with the emergent Trust strategy has begun, and a paper setting out the proposed roadmap for assimilation of the improvements within substantive governance was considered. The committee has also considered an analysis of the undertakings, and the extent to which the progress has satisfied the requirements. The committee has commissioned a further report to be considered in February 2025.

2. **Progress and performance over the previous reporting period**

During quarter three the following progress has been made:

a. The rightsizing theatre capacity programme's move of colorectal cancer services has been approved and is being implemented, and a full response to the Royal College of Surgeons' report has been prepared, setting out progress and next steps.

b. Under the planned care work stream, notable positive feedback has been received from Professor Briggs on progress made.

c. November cancer performance has been confirmed at 71% for 28 day and 63.8% for 62 day, above the tier 1 improvement trajectory.

d. Of the 28 CQC required 16 actions have now been completed, with the remaining 12 have clear actions to complete.

e. Trust has selected new provider to complete external developmental review for Well-Led

f. Ambulance 60-minute breaches are in line with monthly trajectory target.

g. Work has continued to scope a full Culture Strategic Initiative alongside other actions including on management and leadership, values and behaviour and organisational development interventions.

h. Complaints targets have been met, the SJR backlog has been eradicated, there has been continued improvements in the fundamental standards of care programme and the NICE guidance review has continued to improve.

3. **Performance and assurance**

Against the plan's domains, the following programme progress is provided by executive leads and SROs, using the risk rating table detailed below.

i. Maternity: Clinical midwifery staffing fill rate is improving – trajectory <4% vacancy by Jan (Nov 6.40%). All maternity support worker vacancies recruited to in the November recruitment event. There has been successful recruitment into overarching obstetric and neonatal clinical director and permanent head of midwifery roles. Further reduction in Perinatal mortality rates in November (2.44/1000 births vs 5/1000 births national benchmark rate) and an increase in FFT positive rating 95.05%

ii. Quality improvement: Positive progress in some measures, such as complaints with the target of fewer than 300 open complaints met, 100% of clinical guidelines now have a named lead, national audits have increased and fundamental standards of care audits demonstrates increased compliance with NEWS. However, there is further work to ensure improved compliance with some care audits. There is a requirement to consider how a strengthened compliance function and divisional resources can support further progress and assurance of compliance with regulations. This work is underway, and a plan is being formed linked to affordability.

iii. CQC: Additional support for CQC action plans was aligned to refreshing the oversight and evidence review. This has resulted in a further eleven actions being closed in Q3 (70% actions closed), with approximately 90% evidence to close by March. Oversight on delivery is via the CQC improvement group through to Quality Committee.

iv. Culture: Culture programme now has an appointed SRO and mobilisation is in progress. Prioritisation of actions underway and a business case for organisational development and culture resource is being prepared. STAM compliance is above target however sickness are higher than the target level.

v. EDI: The programme continues to deliver its business-as-usual activities.

vi. Planned care: Speciality level actions now confirmed in place for T&O, ENT, Ophthalmology, Dermatology, T&O and General Surgery; ENT visited by GIRFT; on-call ENT model commended; and governance is now live. 52 week performance is in line with the improvement trajectory and there is a downward trajectory for 65 weeks performance.

vii. Surgery: 21 of the 43 (vs 16 from previous month) recommendations have now been addressed with evidence on progress and/or completion.

viii. UEC: Developments include a UTC workshop delivered with key clinical/operational/service provider stakeholders with key actions agreed and the introduction of Hub model at RSCH to enable streaming directly from SECAMB. Further expansion of the surgical assessment unit at RSCH with an additional six trolley capacity has also been delivered. Performance against 4- and 12-hour waits is off track. 6.5% of ambulances breached 60 minutes, which is in line with monthly trajectory target.

ix. Specialised services: There has been an improved SSQD submission, and all Q2 reporting requirements as per plan were met.

x. Cancer: There has been progress against 62 day and 28 day faster diagnosis standards.

4. **Activity not completed in line with plan**

i. There is decreasing or static 4- and 12-hour performance at all sites apart from RACH.

ii. There has been a delay with all specialities confirmed top 5 GIRFT further faster recommendations and speciality level improvement groups going live but a revised target date for completion of January set.

iii. Surgical operating model has been de-scoped

iv. Harm free care programme is being re-scoped with revised plans

v. All CQC must dos were not closed by December 2024 and work continues.

vi. Agreement of standardised divisional quality roles delayed due to affordability pressures but plans now being formed and a revised date is being set.

vii. The specialised services plan for divisional level tabletop review process and confirmation of key service level elements of safety, quality, performance, activity and finance is delayed and a revised deadline has been set for January

viii. The independent review of Well-led did not proceed as planned due to the withdrawal of the provider, however a new provider has been secured and an implementation plan developed.

5. Expected delivery in the next period (January to March)

The following activities and delivery are planned for the next quarter:

i. Completion of Mechanical Thrombectomy Business Case

ii. Development of a proposal for a compliance function and divisional quality rightsizing linked to affordability plans.

iii. Enable all evidence to be available for CQC and to complete the must do actions. Determine how compliance with surgery cancellation policy is monitored and reported

iv. Well-led review - work with the new provider with the aim to complete the review in May 2025

v. Capture and agreement of self-assessment against national best practice for UTC and Frailty services cross Trust as part of UEC plans.

vi. Under planned care, confirm outstanding top fives per speciality and complete review along with producing a programmatic plan outlining key milestones and deliverables for each speciality to March 2025.

vii. Final version of Continuous Flow Model taken forward for ratification through Trust governance.

viii. Trust to submit funding proposals to cancer alliance to support new projects in 25/26

During Q4, the SIP committee will also consider its constitution and its aim to enable sustainable delivery of its objectives outside of the fixed term governance of the committee, linked to a consideration of the satisfaction of the undertakings.

CONCLUSION

Reasonable progress has been made in Q3 including the delivery of the RTT >52 weeks trajectory, quality improvements, progress in closing CQC actions and in building the foundations for mature commissioning

conversations on specialised services. Priorities for Q4 include plans for assimilating the improvement plans into substantive governance and to the new strategy in Q1 2025/26.
The Board is asked to **NOTE** the report

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Agenda Item:	11.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	2024/25 - Quarter 4 BAF				
Sponsoring Executive Director:	Chief Executive				
Author(s):	Company Secretary				
Report previously considered by and date:	The proposed quarter 4 BAF was considered by the Audit Committee 21 January and the BAF allocated risks were considered by each Board Committee in their meeting in the last week of January 2025.				

Purpose of the report:			
Information	N/A	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	Yes
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The BAF covers the strategic risks for this domain.
Sustainability	Yes	The BAF covers the strategic risks for this domain.
People	Yes	The BAF covers the strategic risks for this domain.
Quality	Yes	The BAF covers the strategic risks for this domain.
Systems and Partnerships	Yes	The BAF covers the strategic risks for this domain.
Research and Innovation	Yes	The BAF covers the strategic risks for this domain.

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

The Trust is required to have an effective system of governance, risk management and internal control for which an effective BAF is key component. Commentary on the effectiveness of these processes is required within the Trust's annual governance statement and is subject to audit review and comment.

Communication and Consultation:

Report:

Introduction

The purpose of this report is to provide assurance to the Board that the Trust's Board Assurance Processes have been applied across the quarter. These processes see the respective executive leads for each strategic risk undertake a review of the assurances received and consider as to what they say in respect of the controls in place to reduce the specific strategic risk. In considering this information along with the progress against the key actions the Executive then determine the current risk score and if further actions are needed to address identified control or assurance gaps. The Executive view is then shared with the respective allocated oversight Committee for each strategic risk who consider this view in the context of the reports and assurances they have received and considered. Complementing these reviews is the work of the Audit Committee that consider the underpinning processes.

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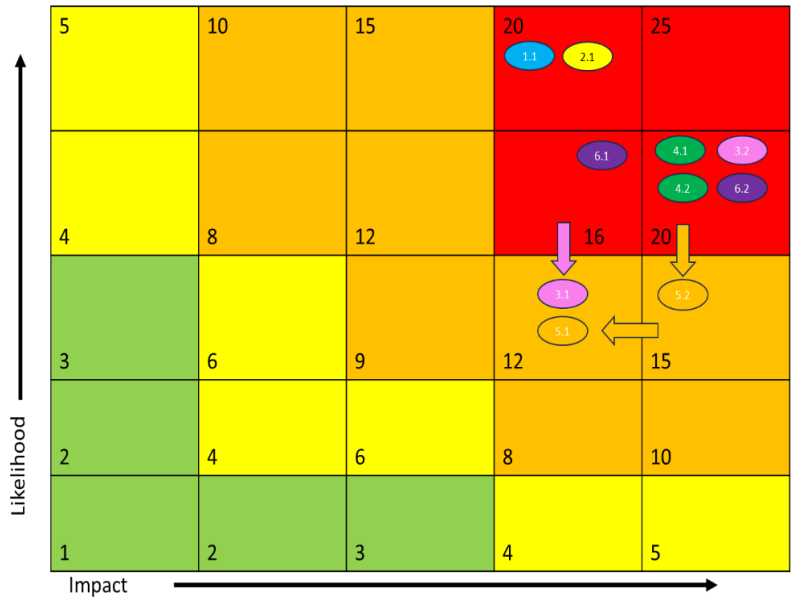
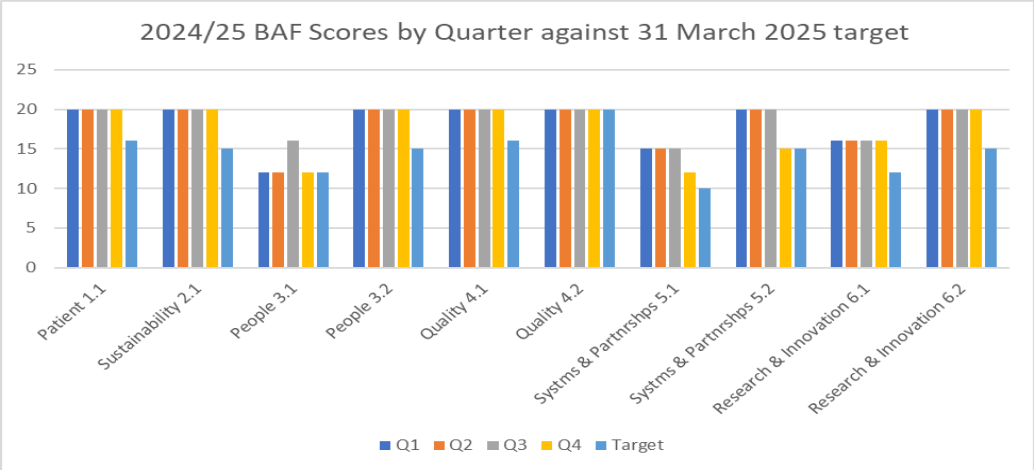
Quarter 4 BAF Overview and Context

For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the proposed quarter 4 score, which have been scrutinised by their respective oversight committee.

For each of the 10 strategic risks assurances have been received over the period of quarter 3 enabling a determination to be made as to the quarter 4 score. Based on this executive review of their respective strategic risk is recommending to the Board via the respective oversight committees that there are to be **THREE CHANGES** to the risk scores at quarter 4.



Below is a summary chart showing for the 10 Strategic Risks their quarter 4 scores and the distance from their respective target score.



At quarter 4 there are SEVEN strategic risks which will not achieve its year-end target score, these being risks 1.1, 2.1, 3.2, 4.1, 5.1, 6.1 and 6.2 but noting that risk 5.1 has reduced from a significantly scored strategic risk.

University Hospitals Sussex
NHS Foundation Trust

Committee review

Following the review by each of the Board Committees during their last round of meetings where then considered the risks for which they have allocated oversight each agreed the scores reflected in BAF for quarter 4 are fairly represented specifically in respect to the reduction in score for risks 3.1, 5.1, and 5.2.

Conclusion

The BAF continues to record the receipt of assurances with the most prominent mix of management and executive assurance being provided, however there has been a number of externally provided assurance from Internal Audit, the Guardian Service, FFT results etc. Whilst there were a small number of sources of expected assurance for quarter 3 which did not materialise, the respective oversight committees did not feel these impacted on the quarter 4 scores and received information on the plans to receive these assurances in the future.

For quarter four whilst the scores for three strategic risks have reduced, the Trust continues to see seven of its ten strategic risk highly scored.

Recommendations

The Board is recommended

- to **NOTE** that the continued application of the Trust's BAF oversight processes applied by the Executives and the respective oversight Committees.

- to **AGREE** the BAF scores for quarter 4 are reasonable based on the review undertaken by the respective Board Committees and the Board itself through the receipt and discussion of the Trust Integrated Performance Report.

- to **REFLECT** on the level of risk being held by the Trust in the last quarter of the year as it considers its operational plan for 2025/26 in forthcoming meetings.

University Hospitals Sussex NHS Foundation Trust

2024/25 Quarter 4 Board Assurance Framework Report

1 Introduction

1.1 At the Board workshop where the Trust's strategic risks were considered the Board reflected that their needed to be clearer delineation of some of the prior strategic risks and that their needed to be a specific risk in relation to the Trust's digital maturity, this culminated in 10 strategic risks being defined for 2024/25.

1.2 The Board approved in June the Trust's 10 2024/25 strategic risks alongside their target score to be achieved by 31 March 2025 and their longer-term goal score aligned to the Trust's risk appetite statements.

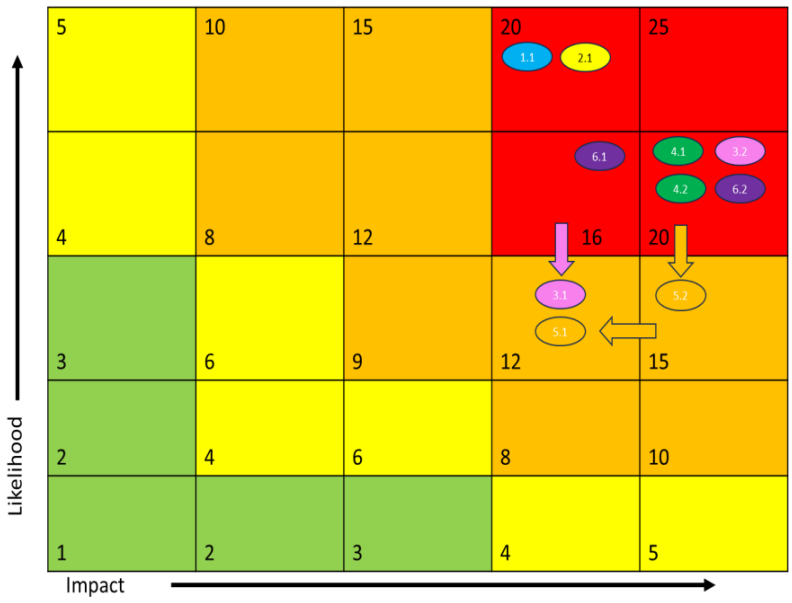
1.3 As in prior years each Strategic Risk has an Executive lead and is grouped within one of the Trust's six strategic domains with each domain being aligned to their respective allocated oversight Committee.

1.4 The Board Assurance Framework process sees the respective executive leads for each risk review the assurances received and consider what they say in respect of the controls in place to reduce the specific strategic risk. In considering this information along with the progress against the key actions the Executive determine the current risk score and if further actions are needed to address identified control or assurance gaps. The respective oversight Committees will through their meetings consider the proposed Quarter 2 risk scores against the assurances received to enable them to provide a recommendation to the Board.

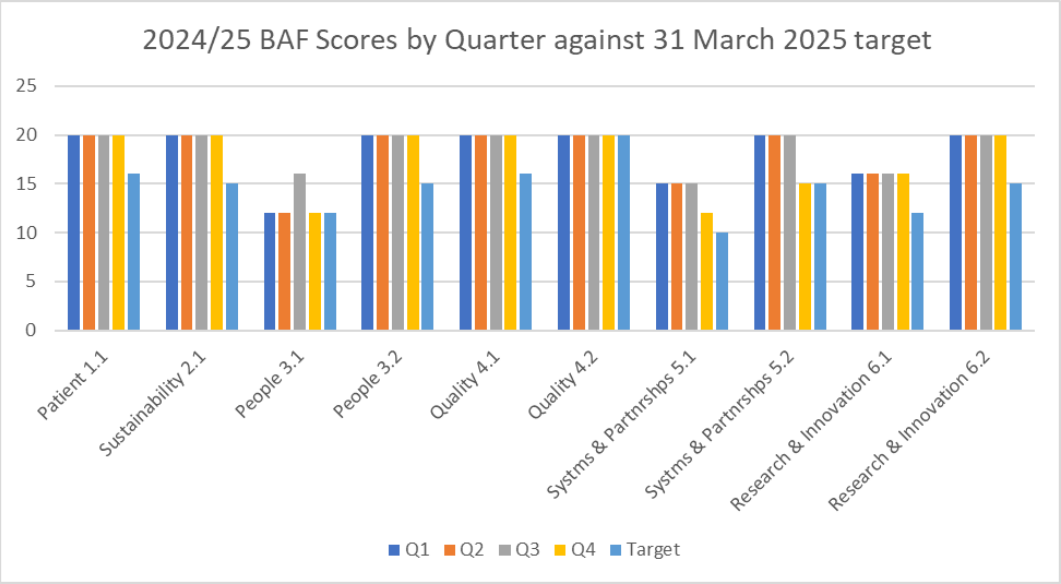
2 Quarter 4 BAF Overview and Context

2.1 For each segment of the BAF the respective lead executive has considered their risks along with the supporting highly scored and corporate risks when determining the proposed quarter 4 score, which was then scrutinised by the respective oversight committee.

2.2 For each of the 10 strategic risks assurances have been received over the period of quarter 3 enabling a determination to be made as to the opening quarter 4 score. Based on this executive review of their respective strategic risk is recommending to the Board via the respective oversight committees that there are to be **THREE CHANGES** to the risk scores at quarter 4.



2.3 Below is a summary chart showing for the 10 Strategic Risks their quarter 4 scores and the distance from their respective target score.



Appendix 1 shows the summary of changes in the BAF risks over 2024/25 to date

3 Movement in the Quarter

3.1 **TWO risks, people risk 3.1, and performance risk 5.2 have reduced to their target score of 12 in the quarter, with ONE risk also reducing this being risk 5.1 relating to merger benefits seeing this score reduce to 12, therefore no longer scoring significantly. (noting risk 4.2 whilst scoring significantly remains at it target score of 20 for the year)**

- **People – Risk 3.1** *We are unable to recruit and retain a sufficient level of workforce if we do not have effective support for staff across the breadth of the NHS people promises (covering inclusion, health and safety, learning, recognition, teamwork, flexibility & staff voice) which adversely affects our capacity and capability to deliver services, continuous improvement and Patient First TNs.* The target score is 12 and with the interventions being delivered the risk is proposed to reduce although there is deterioration in staff positive feedback and a reduction in engagement with the staff survey the overall level of action taken supported by a steady vacancy level, improved level of appraisals and the continued work on staff health and wellbeing.

- **Systems and Partnership – Risk 5.2** *We are unable to deliver and demonstrate consistent compliance with the 24/25 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and the Trust's reputation and financial position.* Significant work has been undertaken to improve the Trust's RTT, Cancer and UEC performance. Whilst there remains significant challenges in achieving the Trust's activity plans, the enhanced plans put in place and reported through to the NHS E the executives have increased confidence the risk score can be reduced to its target score by the year end.

- **Systems and Partnership – Risk 5.1** *We fail to realise the benefits of merger and the strategic intention of 3Ts because we are unable to successfully develop and deliver plans to optimally configure our sites and services in a way that aligns with system partners and our ICS strategy.* The delivery of the actions is progressing especially in

respect of the developing Trust Strategy is seeing the risk reduce closer to its target score.

3.2 **SEVEN of the strategic risks are exceeding the Board agreed target score (that to be achieved by 31 March 2025, but one of these risks has moved down from a significant score)**

3.3 At quarter 3 five risks were flagged and recognised by the Board as having little confidence that the risk could be reduced its target score, these being 2.1,3.1,3.2, 4.1 and 5.2. At quarter 4 this has changed to **SIX risks where the executive judgement is that the risk will not achieve its year end target score, these being risks 1.1, 2.1, 3.2, 4.1, 6.1 and 6.2**

4. Committee Review

4.1 Each Committee considered the reports they received and the assurances these provided over the controls and mitigations in place against their allocated strategic risks alongside the information recorded within the BAF document itself.

4.1.1 Patient and Quality Committee

The Committee agreed that for the patient strategic risk the score should not change given the overall decline in FFT scores over the year although the Committee did recognise that within the area of improving the complaints response times significant improvement had been made in Q3 and within a number of patient surveys satisfaction scores had increased.

The Committee agreed that for the quality risk, 4.2, they had continued to receive sufficient assurance that this risk remained at its target score and thus the score did not need to change. The Committee recognised that the Board in setting this target score at 20, had itself, recognised the timeline for all the planned quality improvements to be delivered would be after the year end.

The Committee agreed that the score for the other quality risk, risk 4.1, this should not reduce this quarter, and that whilst actions are being taken the work to fully address all the CQC recommendations, those needing infrastructure investment will take longer than this year to be delivered and therefore shared the view that this risk will not achieve its target score by the year end.

4.1.2 People and Culture Committee

The Committee agreed that the score for people risk 3.1 should decrease for quarter 4 based on the overall assurance levels and the triangulation with the stable turnover rate, the work done to attract new staff coupled with steady appraisal rate performance.

The Committee also reflected that whilst work is being undertaken to address many of the drivers for the people and culture risks, risk 3.2 as had been accepted at the November Board would not see a reduction in score in the second half of the year as many of these actions need more time to deliver measurable change.

4.1.3 Finance and Performance Committee

The Committee has oversight of three risks, risk 2.1, 5.1 and 5.2.

In considering the finance and performance risk 2.1 the Committee reflected on the challenges the Trust is facing and agreed that the marginal reduction in score to achieve its target score by the year end would not be possible.

The Committee recognised the level of executive confidence that the actions taken and those planned across quarter 4 for both risks 5.1 and 5.2 supported a reduction in both these risk's scores. The Committee did however recognise the degree of challenge within the delivery of Trust's planned care and cancer and unscheduled care performance.

4.1.4 Research, Innovation and Digital Committee

The Committee agree the scores for quarter 4 for the two risks it has allocated oversight for. risks 6.1 and 6.2 should not change, and whilst work is being undertaken these actions will not see a reduction by the year end. For both the research and digital strategic risks the Committee noted the actions in place to reduce these risks but accepted that these would not deliver by the end of the quarter.

4.2 **Following the review by each of the Board Committees during their last round of meetings considered the risks for which they have allocated oversight each agreed the scores reflected in BAF for quarter 4 are fairly represented specifically the decrease in risks 3.1, 5.1 and 5.2**

5 Summary

5.1 Below is a summary of the strategic risk review undertaken by the executives, showing the rationale for the proposed Q4 score, the assurances received across Q3 detailing if provided by operational management, executive led oversight or externally, the summary of future actions and the timeline to achieve the 31 March 2025 target score and any flagged risk to this delivery.

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
1.1	20 (no change)	Risk scores remain elevated as patient reported experience for most touchpoints is declining, there remain continued issues with performance in main drivers of patient experience (waits for planned care, ED treatment times), complaints received are increasing and there has been a decline in reported patient experience within in patient areas in the latter part of quarter 3.	1. FFT recommendation rates (ext) 2. Number of formal complaints & PALS concerns (ext) 3. CQC National Surveys (ext) 4. Healthwatch reports (ext) 5. Patient Experience reporting (op and exec) 6. QGSG report on divisional learning and complaints response levels (op) 7. Quality Scorecard (op and exec) *Gaps in assurance received in Q3* *Divisional Improvement Plans*	The main drivers of poor patient experience remain waiting – for planned care, and for urgent or emergency care. Work continues to implementation the RTT plans. For UEC where there has been less of a performance improvement then the UEC improvement plans are being subject to review by the interim deputy COO. The continuation of the complaint's improvement work will continue to reduce the over 60 days complaints during Q3. Two key actions have been added given that a change in risk score has not been achieved which relates to the implementation of the welcome standards across the Trust to improve patient experience, and targeted training for doctors and other staff to reduce concerns about staff attitude	**The target score is not expected to be achieved by the 31 March**

University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
2.1	20 (no change)	The risk score is maintained at 20 for Q4 24/25. The resubmitted financial plan for the Trust of £19.4m deficit (covered by deficit funding of £19.4m, requiring a reported breakeven position) generated an implied efficiency required of above £80m. In Q3, the Trust has recognised a £30m shortfall in the CIP programme, as well as operational pressures, and appointed an Efficiency Director with a focus on reducing costs and developing a multi-year efficiency programme. The Efficiency Director has identified £41m of in-year opportunities for improvement and is supporting the Executive and wider leadership team in delivering these opportunities. The new CFO is working with the Efficiency Director to validate and confirm delivery of these savings, and to develop a robust financial forecast to the year end. The Trust has indicated to regional and local regulators that delivery of the resubmitted financial plan is likely to be challenging and is working on a more robust forecast for the year end deficit position which recognises system pressures and challenges as well as Trust areas for improvement.	1. CFO reporting to Sustainability (financial scorecard and risks) (Exec) 2. Productivity Reporting 3. Tender waivers, losses and comps reporting (Exec) 4. Capital Programme report (ops and Exec) 5. Efficiency programme report (op and exec) 6. Workforce deployment reports to People Committee (ops and exec) 7. ICS assurance meeting (ext) 8. Tender waivers, losses and comps reporting (Exec) 9. IA review of internal control environment (ext) and LCFS reporting on control environment (ext) 10. Reporting on DoI and FPP (op and exe) 11. Commercial activity reporting (op and exec) 12. Exec reporting of enhanced control environment (exec) *No identified gaps in assurance in Q3*	The proposed actions continue to be pursued these include • Complete the risk assessment of efficiency schemes and opportunities • Complete the rapid review of the operation of control environment with corrective action where weaknesses or opportunities are identified • Bridge risk adjusted gap to target and develop multi-year approach.	**The target score is not expected to be achieved by the 31 March (noting this was discussed and agreed by the Board in November 2024)**

NHS University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
3.1	12 **(decrease)**	This risk is proposed to **DECREASE** back to its target score. A 2023/24 people plan was approved by the People Committee in May. This set out key activities for the year based on the staff survey, single improvement plan and other information. The Trust also finalised a workforce plan as part of the annual plan to the ICB. Broadly the Trust has maintained a consistent level across sickness, vacancy and appraisal and STAM and other people metrics. Turnover has continued to decline. However operational pressures and the financial challenges faced by the Trust and NHS as a whole continue to have an impact of staff feeling stretched. Although staff engagement did not appear to be impacted by this in Q1, as expected as the impact of grip and control measures are felt, coupled with a national narrative around NHS deficiencies, staff engagement fell in Q2 but has been marginally improving in Q3. There are interventions in place, such as the Big Conversation and progress in resolving some pay issues which can help mitigate (eg HCA banding), but also difficult decisions such as back pay not being made on bank work.	1. People scorecard (ops and exec) 2. LCD reporting to People Committee / Trust SDR (exec) 3. Equalities and Inclusion reports (ops and exec) 4. WRES and WDES report (ops and exec) 5. Patient First Strategic Initiative Programme report 6. H&W steering group reporting to People Committee (exec) 7. H&S Committee Chair report (ops) 8. F2SU Guardian annual report (bext) 9. Guardian of Safe Working Annual Report (ops) 10. Education and Training Assurance report (ops) 11. ER report (Exec) *No identified gaps in assurance in Q3*	Continued implementation of people plan workstreams (inc SIP elements) covering each people promise with particular focus on pay and TCs harmonisation work & engaging with TUs. This includes medical bank and agency work which is proving challenging. Some of these activities will impact morale or motivation as changes are implemented or because the prioritisation of work leaves some issues of dissatisfaction unresolved for longer than others. There is also significant work to undertake supporting some change programmes such as theatre capacity associated service and job plan changes. Maintaining engagement at 2023/24 levels and other staff survey scores the same will be a good result. Staff survey results will be available in Q4.	**The Executive Team propose that the risk score reduce to its target score.**

University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
3.2	20 (no change)	Clear diagnostic work undertaken including cost centre analysis. Metrics for measurement established. Reports developed and discussed at executive and TMC. Plan drafted to support priority culture & OD recommendations and agreed in SIP. Work commissioned to support colorectal redesign, UEC and CSS. OD and culture aligned with Big Conversation and development of the people strategic mission. Cohort 3 of OD skills development recruited and underway. QSIP safety culture programme established as into a co-ordinated programme of work with clear workstreams and deliverables identified. Board development and executive development commissioned and in delivery phase. Launch of active bystander training.	1. People scorecard (ops and exec) 2. LCD reporting to People Committee / Trust SDR (exec) 3. Equalities and Inclusion reports (ops and exec) 4. WRES and WDES report (ops and exec) 5. Patient First Strategic Initiative Programme report 6. H&W steering group reporting to People Committee (exec) 7. H&S Committee Chair report (ops) 8. F2SU Guardian report (ext) 9. Guardian of Safe Working Report (ops) *No identified gaps in assurance in Q3*	Clarity of scope of people mission of the big conversation and worked up plan for delivery. Evaluation of leadership development and scoping and planning next phase of top 70 development including leadership conference. Conclude resourcing discussions for OD delivery. Values behavioural framework completed and associated interventions. Reward and recognition workstream scoped and milestones agreed including pay harmonisation.	**The target score is not expected to be achieved by the 31 March (noting this was discussed and agreed by the Board in November 2024)**
4.1	20 (no change)	No change to risk score as there is continued work being undertaken which includes: 1) New standard work for review quality standards 2) 50% assurance standards to have clinical lead 3) Production Clinical assurance Framework (Trust level) 4) Develop standard work to review mortality outlier	1. Quality Scorecard (ops and exec) 2. Safe Staffing report (annual QGSG and People) 3. QIA reporting (ops and exec) 4. Quality risk reporting (ops / finance) 5. Learning from deaths report (ops and exec) 6. Clinical Effectiveness reporting (ops and exec) 7. Mental Health Steering Group reporting (ops)	The proposed actions include • Completion and roll out of standard work for quality standards review (COEG / division) • To secure 100% assurance standards to have named clinical lead • Confirmation of National audit participation • Standard work to log all national registries / quality	**The target score is not expected to be achieved by the 31 March (noting this was discussed and agreed by the Board in November 2024) year end**

NHS University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		5) NHSE Kloe 6 spec com completed. 6) CQC improvement group established – close all but one pre 2023 actions	*Gaps in assurance received in Q3* *Spec com steering group reporting*	data returns (COEG link to IG) • CAF to be rolled out into each Division • Spec com UHSx steering group established and work plan to be developed to review all specialist com services • Methodology to support reporting on all mortality outliers – learning and action via SDR • CQC improvement group – completion of 50% must do actions. • MSSP – 2/8 outstanding actions to be completed • SJR backlog to be completed	
4.2	20 (no change)	Whilst actions have been taken including • All divisions are commencing to report harm reviews • All sites are compliant with completion Tendable audits >70% • There has been a manual trawl Hosp Acq thrombosis there remains significant work to the completed as recognised within the single improvement plan. Also there is a need to improve divisional	1. Quality Scorecard (ops and exec) 2. Maternity Scorecard (ops and exec) 3. Safer Staffing report (nursing) (exec) 4. Incident report (ops and exec) 5. DoC compliance reporting (ops and exec) 6. Medico Legal update 7. QIA reporting (ops and exec) 8. Quality risk reporting (ops 9. Harm reviews (ops) 10. MSSP report (ext) 11. Birth Rate + report (ext)	The proposed actions include • Harm reviews – confirm std process for documenting and confirming harm • Cancellation rebooking policy • Increase to 100% compliance with all care standards captured in Fsof C audit • NEWS / PEWS 75% (news >5) all sites • SOP for review of Hospital acq thrombosis incl radiology agreed reporting language	**Already achieving target score BUT note this is at a significant risk score of 20**

University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		compliance with the Duty of Candour regulations	12. Learning from deaths report (ops and exec) 13. Clinical Effectiveness reporting (ops and exec) 14. Mental Health Steering Group reporting (ops) 15. Initial reports on Specialist Ventilation and Water Safety (ops and exec) *Gaps in assurance received in Q3* *Routine Specialist Ventilation Group reporting* *Routine Water Safety Group reporting* *QIA reporting*	• Awareness of sepsis – use EPMA audit • Develop theatre ventilation action plan • Evaluate the impact of continuous flow model on ED corridor care	
5.1	12 (**decrease**)	This risk is proposed to **DECREASE** back to its target score. <u>Strategy development:</u> Around 2500 staff, 1300 members of the public and 300 partners have participated in the 'big conversation' to contribute to development of our vision, purpose and priorities. Public Board 7th Nov agreed design principles and themes, informed by engagement and 'as is' problem analysis. Trust leaders are now developing detailed propositions through task/finish and workshop structure. <u>ICS:</u> We are engaged with ICS strategy and	• Clinical Strategy (exec) 1. ICS and Collaborative Networks meeting reporting (exec) 2. CiC reporting (exec) 3. Contracting performance reporting (ops) 4. System people plan reporting (exec) 5. Annual operational plan linked to system priorities (exec). 6. 3Ts corporate project update *Gaps in assurance received in Q3* *Review of 3Ts benefits realisation*	<u>Strategy development & ICS:</u> The Board will be asked to make tier 1 priorities decisions in January with publication of the strategy now planned for April 2025 (a timeline which supports sufficient time for well-balanced decision-making, taking account of options to decompress RSCH, and alignment with the Major Services Review). <u>3Ts:</u> The external stakeholder engagement plan for Sussex Cancer Centre will be mobilised to maximise wider political and charitable support. We will	**The Executive Team propose that the risk score reduce closer to its target score which will see it slightly above its target score but is no longer than significantly scored**

NHS University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		Major Services Review, through Committees in Common and Strategy Director network. First analytical review stage is complete, with initial recommendations expected early 2025. 3Ts: Development of the strong case for a Sussex Cancer Centre has been refreshed with a view to increase external stakeholder support, and we continue to gain assurance from the NHP that our project is not under review as part of the review of the NHP portfolio.		continue to seek NHP & NHSE support for SCC and its revised financial envelope. We will bolster our work to look at the benefits realisation of the LMB under the Interim Efficiency Delivery Director's leadership, as part of his work on Trust efficiency. We have commissioned work on options to decompress RSCH, firstly understanding what needs to be on the site because of population needs, commissioning, clinical adjacencies etc.	
5.2	12 (**decrease**)	There has been no change to the risk profile. The risk score remains at 20 (5x4) driven by. • Core Capacity: Still insufficient to meet demand, necessitating extra-contractual work and system support to manage 78 and 65-week backlogs. The Trust will not see no over 65wk waits by end of September. • Emergency Department (ED) Performance has seen no overall improvement, although at the RSCH site in Q2 and continuing there has been an improved	1. Operational Performance Reporting (exec) 2. Integrated Performance Reporting (exec) 3. Patient First Programme report 4. Clinical Strategy (exec) 5. ICS and Collaborative Networks meeting reporting (exec) 6. Contracting performance reporting (ops) 7. Annual operational plan linked to system priorities. (exec) 8. Capital programme reporting (ops and exec) 9. Workforce deployment reporting (ops) 10. Rightsizing Theatres Programme (ops and exec)	The proposed actions include • 65 Week Reduction Plan: Whilst not meeting the national requirement to have no over 65wk waits the Trust will continue with its plan as agreed with through the Tier 1 oversight process. Working with system partners we expect to have 0 65 week waits by end Q4 • UEC Performance Improvement Plan: A full review of these improvement plans has commenced and its recommendations will be Implemented over the quarter to enhance	**The Executive Team propose that the risk score reduce to its target score.**

University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		performance, although this is counter balanced by a deterioration in other sites such as SRH • Delayed Discharge: There continues to be no significant reduction in patients who do not meet the criteria to reside, impacting overall capacity and flow. The stability of the risk score indicates ongoing challenges in balancing demand and capacity within our services.	*There were no gaps in assurance received in Q3*	Emergency Department performance to 78% four hour performance by end Q4 • Rightsizing Theatre Capacity Programme: Continue with the implementation plan to optimize theatre usage. • Length of Stay Improvement: Collaborate with SCFT and the Local Authority to reduce the number of patients who do not meet criteria to reside, improving overall capacity.	
6.1	16 (no change)	The proposal is to see no overall change in risk rating. This is driven by • Sussex house decant postponed for 2-3 years removes short term uncertainty but lack of near-term solution to challenges created by the central research facility in Sussex house persists • Increased commercial commitments from 2025 onwards will create additional pressure on this facility. • Divisional research plans drawn for 2025-26 and moving towards implementation • Agreement of NHS Sussex Research Strategy	1. Trust strategy refresh tracked via CSO and Exec 2. R&I programme reporting (ops and exec) 3. Inclusion digital into the R&I strategic steering group – development program *Gaps in assurance received in Q3* *Lack of future CRF on RSCH site* *Lack of plan for NMAP divisional leads* *Gap in digital development road map year 1-3 prior to EPR*	The following actions are to be delivered across the coming quarter • Scope RI infrastructure needs as part of strategic planning and ensure clinical research infrastructure is in relevant strategic planning and capital discussions/prioritisation • Actively engage in strategic planning to secure options for reprovision of CRF at RSCH site • Plan and implement research hubs at SRH, WH and PRH with clinical research space and associated support services in line with	**The target score is not expected to be achieved by the 31 March**

University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
				commercial research delivery ambition. • Develop research leadership in the non-medical professions • Implement sustainable model for embedded research into job planning • Develop approaches to sustainable research support development radiology, pathology; R+I workforce • Develop governance and support for the Trust's digital innovation function	
6.2	20 (no change)	National benchmarked scores have been released (Nov 2024) and the Digital Capability Framework score indicate a score of 1.9 out of 5 for UHSussex. **This is well below national and regional average indicating low digital maturity**. We have achieved 'standards met' against the Data Security Protection Toolkit for 2024/5. Now preparing for the Cyber Assurance Framework assessment; the initial assessment is due to be submitted in Dec '24. The EPR OBC continues through Cabinet Office Spend Control process with pre-market engagement throughout November/December 2024. The risk to resilience is linked to the	1 EPR Programme progress update (ops) 2 DSPT update (ops) 3 Health Records Improvement plan (ops) 4 EDMS Project delivery (Ops) 5 IT Capital Programme (Ops) *There were no gaps in assurance received in Q3*	The following actions are to be delivered across the coming quarter • Based on our DMA and DSPT assessments, we will develop our Digital & Data Strategy 2025-30 and priority improvement action plan for 2025/26. • Cyber security improvements to be guided by the DSPT assessment. • EPR pre-market engagement will inform the refinement of the ITT (invitation to tender) for release in Feb 2025 after Cabinet Office Spending review approval. • Contract to be signed for the	**The target score is not expected to be achieved by the 31 March**

University Hospitals Sussex NHS Foundation Trust

Risk	Score	Rationale for proposed Q4 score	Key assurance received in Q3 and any identified gaps	Summary of future actions	Timeline to achieve 31 March 2025 target score
		reinstatement of the data centre. The business case has been supported by BCSP (2nd Dec 2024) and will require ratification by TMC later in December 2024.		reinstatement of the data centre in Dec 24/Jan 25, post governance approval at TMC, for delivery by June 2025. • Delivery of a draft Digital and Data Strategy 2025-30 following engagement with key stakeholders in alignment with the evolution of the Trust-wide strategy. • Evolution of the Digital Literacy Action Plan.	

6 Conclusion

6.1 The BAF continues to record the receipt of assurances with a most prominent mix of management and executive assurance being provided, however there has been a number of externally provided assurance from Internal Audit, the Guardian Service, FFT results etc. There has been a small number of sources of expected assurance for quarter 3 which did not materialise, but the Executives and the respective oversight committees did not feel this missing assurance was significant enough to not allow them to determine a quarter 4 score.

6.2 The respective Board Committees and the Executives have continued to oversee their allocated strategic (BAF) key risks aligned to their patient first domain.

6.3 For quarter four whilst the scores for three strategic risks have reduced, the Trust continues to see seven of its ten strategic risk highly scored.

7 Recommendations to the Board

7.1 The Board is asked to **NOTE** that the continued application of the Trust's BAF oversight processes applied by the Executives and the respective oversight Committees.

7.2 The Board is asked to **AGREE** the BAF scores for quarter 4 are reasonable based on the review undertaken by the respective Board Committees and the Board itself through the receipt and discussion of the Trust Integrated Performance Report.

7.3 The Board is asked to **REFLECT** on the level of risk being held by the Trust in the last quarter of the year as it considers its operational plan for 2025/26 in forthcoming meetings.

University Hospitals Sussex NHS Foundation Trust

APPENDIX 1

BAF Summary

The table below overleaf shows by risk, their current score and their target risk score. The table shows pictorially the movement in risk between the current score for Q4 and Q3
(No change, ⟷ an increase in risk ↑ and ↓ a decrease in risk)

BAF: Strategic Objectives and Strategic Risks (Key: I = Impact L = Likelihood T = Total)	**Risk Scores**														
	2024/25 Q1			**2024/25 Q2**			**2024/25 Q3**			**2024/25 Q4**			**2024/25 Target**		
	I	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**	**I**	**L**	**T**
1 Patient ***(Oversight provided by the Patient & Quality Committee)***															
1.1 We are unable to deliver or demonstrate a continuous and sustained improvement in patient experience resulting in overall poorer patient experience and potential for adverse reputational impact.	4	5	**20**	4	5	**20** ⟷	4	5	**20** ⟷	4	5	**20** ⟷	4	4	**16**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**NEW will NOT achieve target score**		
2 Sustainability ***(Oversight provided by the Finance and Performance Committee)***															
2.1 We fail to deliver the in-year financial plan; alongside the requirement to return to a breakeven run-rate by M12 2025/26 and secure medium-term sustainability	5	4	**20**	5	4	**20** ⟷	4	5	**20** ⟷	4	5	**20** ⟷	5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			Previously reported as will NOT achieve target score		
3 People ***(Oversight provided by the People and Culture Committee)***															
3.1 We are unable to recruit and retain a sufficient level of workforce if we do not have effective support for staff across the breadth of the NHS people promises (covering inclusion, health and safety, learning, recognition, teamwork, flexibility & staff voice) which adversely affects our capacity and capability to deliver services, continuous improvement and Patient First TNs..	4	3	**12**	4	3	**12** ⟷	4	4	**16** ↑	4	3	**12** ↓	4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**At target score**		
3.2 We will not achieve our strategic aims and realise the benefits of merger, including improving patient safety and recruiting and retaining talent unless we take action to; develop a clear strategy, invest in and prioritise focussed work on culture change from 'Board to Ward' including developing our leaders to be engaging, inclusive and empathetic, aligning sub-cultures and addressing cultural gaps and reducing cultural variation	5	4	**20**	5	4	**20** ⟷	5	4	**20** ⟷	5	4	**20** ⟷	5	3	**15**

Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			Previously reported as will NOT achieve target score		
4 Quality *(Oversight provided by the Patient & Quality Committee)*															
4.1 We are unable to demonstrate compliance with regulatory and quality standards	5	4	**20**	5	4	**20**	5	4	**20**	5	4	**20**	4	4	**16**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***						Previously reported as will NOT achieve target score		
4.2 We are unable to deliver any safe and harm free care	5	4	**20**	5	4	**20**	5	4	**20**	5	4	**20**	5	4	**20**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**At target score**		
5 Systems and Partnerships *(Oversight provided by the Finance and Performance Committee)*															
5.1 We fail to realise the benefits of merger and the strategic intention of 3Ts because we are unable to successfully develop and deliver plans to optimally configure our sites and services in a way that aligns with system partners and our ICS strategy.	5	3	**15**	5	3	**15**	5	3	**15**	4	3	**12** ↓	5	2	**10**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			Actions in quarter 4 are expected to see this risk reduce closer to its target score		
5.2 We are unable to deliver and demonstrate consistent compliance with the 24/25 operational plan and NHS constitutional standards resulting in an adverse impact on patient care and the Trust's reputation and financial position.	5	4	**20**	5	4	**20**	5	4	**20**	5	3	**15** ↓	5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**At target score**		
6.Research and Innovation (Oversight provided by the Research, Innovation & Digital Committee)															
6.1 We are unable to capitalise on research innovation and digital as drivers of transformational improvement at the Trust. *(revised risk description from Q3 onwards)*	4	4	**16**	4	4	**16**	4	4	**16**	4	4	**16**	4	3	**12**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**NEW Will NOT achieve target score**		
6.2 Our digital immaturity in our infrastructure, skill and technology threaten our security, operational and clinical performance and limit our ability to realise the benefits of digital transformation	5	4	**20**	5	4	**20**	5	4	**20**	5	4	**20**	5	3	**15**
Assessed strength of control	***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			***Some weaknesses***			**NEW Will NOT achieve target score**		

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Maternity Assurance Reports				
Sponsoring Executive Director:	Maggie Davies, Chief Nurse				
Author(s):	Stephanie White, Head of Divisional Quality & Safety / Emma Chambers, Director of Midwifery				
Report previously considered by and date:	Quality Governance Steering Group - 20 January 2025 Patient & Quality Committee, 28 January 2025				

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	Yes	Approval / Agreement	Yes / N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	Yes / N/A	Staff confidentiality	Yes / N/A
Patient confidentiality	Yes / N/A	Other exceptional circumstances	Yes / N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	
Sustainability	Yes	
People	Yes	
Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	Yes	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

All papers have been approved at divisional safety and quality forums

Executive Summary:

Perinatal Quality Surveillance report – November data.

Escalations for January meeting

- Solution not yet found for separate theatre access for planned caesareans on the Brighton site following successful pilot.
- Heating system in delivery suite theatre at PRH extremely fragile, impacting on access to theatre in emergencies.

Celebrations for January meeting

- Further reduction in perinatal mortality rates, December rates less than half the most recently available national rate.

- Successful recruitment to obstetric and neonatal clinical directors for whole service and permanent heads of midwifery
- Antenatal and newborn screening Quality Assurance visit completed by NHSE on 7th January 2025, no urgent/ immediate actions, evidence quality highly commended, improvement work commended. Some recommendations made; an action plan will be developed.

ATAIN – Q2 Progress
Summary

- For the total of Quarter 2, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (1.0%, 2.3% & 1.1%). SRH met the benchmark in July & September (4.0%, 5.9% & 1.6%). PRH and RSCH met the benchmark in August only (PRH - 6.8%, 4.85%, 6.42%, RSCH 6.0&, 4.7%, 6.0%).
- There were 27 admissions to NNU from RSCH, 34 admissions from PRH, 23 admissions from SRH and 18 admissions to from WH which is a total of 92 term admissions to the SCBU/NNU.
- The majority reason for admission this quarter across all four sites was again due to respiratory support.
- Overall, 92.4% (85) of admissions across all four sites were considered unavoidable with appropriate management with 7.6% (7 cases) considered as potentially avoidable. This is a reduction of 1.9% (from 9.5%) when compared to Q1.

Transitional Care – Q2 Progress
Themes

- Treatment with IV antibiotics was the main course of treatment across site.
- Daily neonatal reviews need to be documented in Maternal BadgerNet under the Baby postnatal record; however, it was found the location of documentation varied. This continues from last quarter.
- Delay in neonatal team reviews being performed/documented on BadgerNet due to staffing constraints or increased workload pressures on the unit.
- Several babies are admitted to NNU for short periods of observation, before being transferred back to the postnatal ward.
- Poorer completion of neonatal observations at SRH and WH.
- Challenges continue to conduct daily ward round of TC babies at PRH.

Recommendations

- Implementation of Postnatal Theme of the Month. This will be like the new Maternity theme of the week, but focus on issues on the Postnatal ward, and will be discussed at safety huddles each day throughout the month to ensure all staff are aware. The first two themes will be around escalating concerns and the use of SBAR handovers for babies transferring between wards. This still needs to be implemented and is the focus of the new year.
- QI project across all four sites focussing on neonatal care with a focus on hypoglycaemia, feeding and SBAR
- Review and align neonatal guidance across all four hospital sites.
- Review and increase paediatric staffing capacity at PRH.
- In person paediatric review required when baby identified as requiring phototherapy.

Key Recommendation(s):

The Board is asked to **NOTE** these reports.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	13.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Research, Innovation and Digital Committee Chair Report to Board				
Sponsoring Non-Executive:	Jackie Cassell, Non-Executive and Committee Chair				
Author(s):	Jackie Cassell, Non-Executive and Committee Chair				
Report previously considered by:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	Yes
Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	N/A	
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	Yes	Links to risk 6.1

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Research, Innovation and Digital Committee met on the 29 January and was quorate, as it was attended by two Non-Executive Directors including the Chair and at least two executives. The Chief Medical Officer and the Chief Strategy Officer were in attendance.

In attendance at the meeting were also the Chief Information Officer, the Clinical Research Director, the Director of Operations Research and Innovation, the Managing Director of Planned Care and Cancer, the Director of Integrated Education and the Associate Commercial Director. The Company Secretary and the Deputy Chief Nurse (workforce & professional standards) gave apologies.

The Committee **received** and **NOTED** its scheduled reports that included:

- **Research and Innovation & Digital Steering Group Chair's report** The Committee received the report that introduced the areas discussed in detail at earlier meetings (It remained aligned to areas of risk on the Board Assurance Framework (BAF) with reports on workstreams, their challenges and decisions. Of particular importance remained the need for a sustainable Clinical Research Facility and risks from a lack of Research Innovation in Clinical Job Plans. The previously recognised lack of a Joint UHSussex & ICB Research Strategy was close to being resolved following closely aligned ICB work described in the Strategy update.

- **Research Activity Report and dashboard**. The Committee **received** updates against summary scorecard covering 28 areas linked to patient participation; efficiency and effectiveness; staff involvement

and innovation. The Committee **NOTED** that the arrangements now align to our strategic aims with the emphasis on commercial and interventional research because they bring new treatments to our patients earlier. These are now reflected in appropriate KPIs reflecting the Trust's developing portfolio and ambitions. The closure of the large low intensity study meant the Trust was as anticipated behind its Breakthrough Objective on patient recruitment, but the Committee was **ASSURED** the Trust will achieve NIHR requirements with no adverse financial impact, and notes the revised focus on interventional and commercial studies. The Committee heard that a new large-scale low intensity study would be starting in the new year, which would impact on overall participation rates.

- **Research & Innovation Workstream Updates**
  The Committee **NOTED** the Report and the progression with the Strategy launch and embedding the workstreams working with Division Research Leads. There was an update on securing engagement with the non-medical workforce, an important area of focus for further development. The Committee noted the opportunity to celebrate the PhDs achieved by Trust nurses and the opportunity to capitalise on non-medical research interest. The risk of extreme operational pressures to protected research time was noted and will be monitored by the Committees. The Committee remains **ASSURED** that embedding research work with Divisional Research Directors is part of normal business and heard how this was further supported through the wide range of awards and fellowships announced. The Committee also welcomed news that fellowship applications showed increasingly diverse interest areas beyond traditional organ specific focus.

  Further to previous updates on the research engagement network focus on reaching underrepresented communities, the Committee celebrated the announced NIHR award of considerable investment over 7 years to support a Commercial Research Development Centre focussed on giving deprived and/or hard to reach patient communities' access to the latest advances in pharmacological research opportunities. This is an important development and the strategic implications will need reflection in due course.

  The Committee was also **ASSURED** by work taking place to improve the diversity of research applications and fellowships and **NOTED** that figures demonstrating this progress will be recorded in the annual report.

  While the Innovation workstream had evolved and reflected important cross referencing for research and innovation including adoption of innovation alongside the wider digital strategy and AI developments, there had been more limited and disparate progress in the innovations area. It was noted that the innovation work had not had the same strategic partnership underpinning as the rest of the Trust's research agenda. Committee members had a fruitful discussion on the opportunities to optimise progress within a longer-term maturity plan for commercial innovation, including furthering the Trusts profile as a successful adopter of innovations from elsewhere.

Research Strategy
The Committee welcomed progress achieved through the Future UHSussex 2030 Strategic Task and Finish Group to outline the key strategic ambition and milestones for research and innovation that the Committee expects to be incorporated into the overall Trust Strategy. The Committee **NOTED** the clear steps required to achieve our strategic ambition and realise the benefits of R&I for the Trust and Sussex patients across a range of domains including quality, recruitment and retention, and patient experience. The Committee discussed these important strategic areas and their roadmap through 2028 for inclusion in the future UHSx 2030 strategy. The Committee **NOTED** the emphasis on recognising research as a transforming function and the role it will play in delivering high quality care as well as in contributing to the Trust's financial and sustainability ambitions. While the Board Assurance Framework already records the current limitation on realising the ambition fully due in party to the physical research infrastructure and also digital maturity, the strategy also addresses the significance of human capacity and the need to build and maintain relationships with academia. The Committee **NOTED** important strategic integration aspects were being progressed with the ICB such that federated monies can be drawn upon. The Committee discussed the hub and spoke model and the approach to both engaging clinicians across all Trust sites and embedding research more deeply in their working lives.

Building on the progress appointing 205 Principal Investigators, the Committee heard about further growth in the associate PI team and good experience to date with research interns that enables early pre-researchers to

be supported by investigators and the benefits of Division lead roles. The Committee reflected on the exponential growth in research opportunities in the event that consultant job plans dedicated to research increased modestly. It was acknowledged that the physical Clinical Research Facility premises was not the only limiting factor to the strategic ambition. The Committee **NOTED** the Executive led review of job planning about to be launched and also that there are recognised opportunities in integrated academic training posts and supervision opportunities in this area.

The Committee acknowledged the importance of research needs having early engagement around digital system needs and asked for consideration of opportunities of AI and Digital innovation for research to be **BROUGHT BACK**.

The Committee praised the work on the Research Strategy so far, and the excellent progress on staff engagement, and the clear articulation of a roadmap. We look forward to how this matures.

Development of Digital & Data Strategy 2025-30
The Committee welcomed further sight of the developing Digital and Data Strategy that outlines its role as a key pillar of the wider Trust Strategy with the outline of the anticipated workplan over the next 3-5 years. The Committee had a wide ranging discussion around the five themes for strategic programmes, grouped under: digitising heath records, enhancing experience through digital; integrating care; One Digital; and Data informed. The committee welcomed seeing how ambitions in these areas had been articulated with areas of action and similarly for their foundational enablers. The Committee was **ASSURED** by coherent work building on those foundations with indicative timescales as a roadmap over the next 3-5 years. The Committee **NOTED** and discussed the current stage of development of the Digital and Data Strategy 2025-30 with a view to finalising the strategic alignment with Trust-wide strategy and forward plans for key programmes of work. It was acknowledged that the national context supported the advancement of Digital and the government ambition to capitalise on opportunities from artificial intelligence (AI). The Committee **NOTED** the governance around digital services discussed at the previous meeting and the strategy shows this will continue to evolve.

The Committee heard how the Chief Information Officer had been engaging staff and partners with this vision giving a strategic direction others can refer to. It was acknowledged that there is a risk that staff frustrated by the pace of the Trust's developments to support productivity would need to be engaged with to ensure they consider and promote any local innovations responsibly in the meantime, cognisant of risks to cyber safety and data security, given this fast moving field offering a plethora of 'solutions'. It is important that clinicians who identify and wish to adopt solutions are supported to surface these, and be supported to ensure synergy and security within the wider digital strategic and operational framework. The Committee was **ASSURED** by updates confirming the strategy vision continued to engage with the broader Sussex community with recognition of future partnership working.

While the implementation of an EPR will bring advancement in a number of areas, there is much to be done in the meantime. The Committee welcomed the inclusion in the strategy of the arrangements by which future progress can be recognised including annual NHS assessment and international standards as well as other options; these will be important to consider given how Digital maturity in the wider environment is anticipated to continue to shift over time.

Digital aspects of the Steering group were reported to the Committee and these included:

- **Digital Security & Protection Toolkit Update**
  The Committee **NOTED** an update on the Trust's submission for compliance to the 2024-5 Data Security Protection Toolkit compliance under the Cyber Assurance Framework and results of the baseline assessment that took place in December 2024 together with the expected compliance that can be reached through the developed action plan, subject to sufficient engagement and progress, prior to submission in June 2025. The Chief Information Officer advised that there would be a requirement for clear assignment of owners accountable for outcomes.
  The Committee had a discussion about the degree of detection of Cyber threats and newly identified risks being reflected in Trust strategy. The Committee asked for an articulation of the Digital risk identification and management governance structures **TO BE BROUGHT BACK**.

- **Electronic Patient Record (EPR) Programme and Projects Reports**
  The Committee heard the positive progress of Cabinet Office approval subject to normal conditions for the UHSussex EPR. The update included work taking place to ensure the invitation to tender is robust and the Committee welcomed news that prospective suppliers remained confident in delivering within the cost envelope for the EPR expected to be introduced in 2027.
  The Committee **NOTED** considerable stakeholder meetings contributing to the Trust's requirements and good progress to recruit prospective evaluators with over 180 individuals coming forward.

  Digital Transformation Update
  The Committee **NOTED** change demand is significant. The Committee received an update on the arrangements through which project support is prioritised and in conjunction with change control processes there had been consideration of confirming an internal service level agreement to be addressed at the Trust Management Committee. The Committee welcomed visibility of these pressures that could compromise the Trust's digital ambitions and **NOTED** plans to mitigate them.
  The Committee heard about work to consider the responsible exploration of further Artificial Intelligence (AI) within the necessary governance frameworks and guardrails and looks forward to an update on this work to be **BROUGHT BACK** as a Deep Dive for this committee.

Risk and Board Assurance Framework

The Committee reviewed the BAF risks for which it has oversight. We **AGREED**, that having regard to both the BAF summary, the Research and Innovation Strategy Delivery risks and the reports considered during the meeting, that the strategic risk score was not expected to change by the end of quarter 3 2024/25. The BAF risk 6.1 is maintained at a score of 16 and consider that this risk remains fairly stated for quarter 4 2024/25 with reduced confidence that the risk will reach its target risk score by April. The Committee **NOTED** more clarity is needed around the implications of the Clinical Research Facility on ambitions to participate in Commercial studies that support the Trust's strategic ambitions and this remains on the Committee's agenda. The Committee **NOTED** that the accommodation of the Clinical Research Facility had been given certainty for a further 2 years with recognition of the intention to move this to the LMB or more suitable facility as soon as possible.

BAF risk 6.2 refers to the Digital Maturity assessment and reflects considerable work to do but proposes no reduction to that score (scoring 20). The changes to the DSPT to a Cyber focussed assessment has been **NOTED** and emerging digital and cyber risks pending fully developed arrangements and the EPR are anticipated.

Key Recommendation(s):

The Board is asked to **NOTE** the Committee received its expected reports and the assurance these reports provided.

The Board is asked to **NOTE** the Committee recommendation that the BAF risk 6.1 is maintained at a score of 16 and that this risk remains fairly stated for quarter 4 2024/25. There are a number of changes around the detail of the risk.

6.2 referred to the Digital Maturity assessment and reflected progress towards an EPR but also a considerable way to go alongside other emerging digital threats so proposed no reduction to that score (scoring 20)

Actions taken by the Committee within its Terms of Reference

The Committee received its expected reports and the assurance these reports provided as summarised above.

Items to come back to Committee / Group (Items Committee / Group keeping an eye on)

- Consideration of opportunities of AI and Digital innovation for research.
- An update on the exploration of further Artificial Intelligence (AI) opportunities within the necessary governance frameworks and guardrails as a Deep Dive for this committee.

University Hospitals Sussex
NHS Foundation Trust

- While a routine item for the agenda, the Cyber Assessment Framework will be brought back with an update on the Action plan with clear ownership for outcomes and any risks with strategy implications. - The Committee asked for an articulation of the Digital risk identification and management governance structures

Items referred to the Board or another Committee for decision or action	
Item	**Who / when**
The Committee agreed to recommend to the Board that the BAF risk score of 16 for Quarter 4 for the Research and Innovation Strategic Risk 6.1 remains fairly stated and the BAF risk score of for the Digital Strategic Risk 6.2 remains fairly stated at 20.	Board February 2025

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RESEARCH AND INNOVATION COMMITTEE CHAIR'S HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**29 January 2025**	**Chair**	Jackie Cassell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Research and Innovation Strategy Delivery			
Research & Innovation Strategy Steering Group: Chair's Report	**Presenter** Chief Medical Officer Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted. (no steering group meeting in January 2025) .
Research Activity - Research Activity Report SDR Scorecard	**Presenter** Chief Medical Officer/ Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted
Trust Research Strategy to 20230	**Presenter** Chief Medical Officer / Clinical Research Director	**Purpose** To discuss & note progress	**Outcome /Action taken** Noted
Research & Innovation Workstream Updates	**Presenter** Chief Medical Officer Clinical Research Director	**Purpose** To note	**Outcome /Action taken** Noted.
Innovation update	**Presenter** Commercial lead	**Purpose** To Note	**Outcome /Action taken** Noted
Digital			
Digital Steering Group Chair's Report	**Presenter** Chief Information Officer	**Purpose** For information and assurance	**Outcome /Action taken** Noted. Research and Digital steering groups,
Trust Digital and Data Strategy to 20230	**Presenter** Chief Strategy Officer/ Chief Information Officer	**Purpose** To discuss and note progress	**Outcome /Action taken** Noted
Digital Security & Protection Toolkit Update	**Presenter** Chief Information Officer	**Purpose** For assurance	**Outcome /Action taken** Noted
Digital Transformation Updates	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted
Electronic Patient Record Programme and Projects Reports	**Presenter** Chief Information Officer	**Purpose** For information	**Outcome /Action taken** Noted
Risk			
R&I and Digital Risk Registers	**Presenter** Chief Medical Officer/ Clinical Research Director/ Chief Strategy Officer/ Chief Information Officer	**Purpose** To discuss and note progress	**Outcome /Action taken** Noted. Request to reflect on a new Committee suitable report format
R&I D Extract of Board Assurance Framework for Quarter 4	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** The Committee noted there were no changes to the R&I or Digital Strategic Risks scores during quarter 3 and reduced confidence that the target risk scores can be reached by the end of March 2025. Emerging risks around Digital also raised.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	14.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Patient & Quality Committee Chair report to Board				
Sponsoring Executive Director:	Lucy Bloem, Committee Non-Executive Chair				
Author(s):	Lucy Bloem, Committee Non-Executive Chair				
Report previously considered by:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	Links to risk 1.1
Sustainability	N/A	
People	N/A	
Quality	Yes	Assurances in relation to risk 4.1 and 4.2
Systems and Partnerships	N/A	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Patient & Quality Committee meets monthly and therefore this report covers three meetings in November and December 2024 and January 2025. The meetings were quorate, attended by at least two Non-Executive Directors and two executives. In attendance at the meetings were the Chief Nurse and/or Chief Medical Officer, the Deputy Chief Nurse for Quality and the Director of Patient Experience, and the Director of Clinical Outcomes & Effectiveness. The Chief Nurse gave apologies to the December meeting and was represented by their deputies. In addition, other key personnel attended the meeting as appropriate to present specific papers concerning Infection Prevention & Control, Health Inequalities, Safeguarding and Estates.

During the quarter the Committee received its planned items including reports on the quality scorecard, Infection Prevention & Control the perinatal quality surveillance dashboards, Patient Safety and Duty of Candour reports as well as the Patient Experience assurance report. The Committee also received quality assurance reports, and reports from the Committee's reporting group: Quality Governance Steering Group (QGSG).

Harm Reviews

The Committee has seen further progress with Harm reviews, that are required for specified areas of treatment delays, in both Trust and Division governance reports. The Deputy Chief Medical Officer provided an update the processes in place and reporting and reported that the focus is on resolving the remaining area of challenge including the Cancer Division and reviewing the Trust-wide standard procedures to bringing these arrangements to a sustainable part of normal business. The Committee welcomed the learning focussed process and engagement with multi-disciplinary teams. The Committee **NOTED** the progress towards an assurance position and has asked for an update **TO COME BACK** to the Committee in three months.

Patient Experience

The Q3 Patient Experience Report was received. The Committee **NOTED** that based on available Friends and Family Test (FFT) data, 89.2% of patients responding in Q3 were satisfied that they have a good or very good experience, which was comparable to Q2 and 2023/24. The committee reflected on the lowest satisfaction ratings continue to be associated with the emergency floors related to waiting which together with inpatient represent over 40% of overall responses and the higher levels of satisfaction reported for areas such as cancer, neurosurgery and maternity.

The Committee **NOTED** reduced complaints in Q3, a drop following 7 months continued increase. There had been continued reduction in the number of long open complaints (those outstanding for more than 60 days) and these represented less than 10% of the open case load. The committee continued to be assured on the quality of responses as the Health Service Ombudsman continues to uphold a very low rate (less than 1%) of the escalations they receive. Key themes of complaints remain waiting in A&E, waiting list issues, cancellations, staff attitudes and behaviours. Work is also progressing to link complaint feedback into Medical Leadership and appraisals. The Committee heard about work to move the successful Welcome Standards into normal business through induction and on the programme of engagement toward the imminent new Visiting Policy that learning from high CQC rated Trusts and patient feedback gives confidence this will improve patient experience.

The Committee **NOTED** the National Maternity Survey report from 2024 that concerned feedback from a snapshot of care in February 2024 and had a 45% response uptake. The Trust ranked 18th out of 56, in the Top 3rd of Trusts an improvement on 20th in 2023. The Committee noted improvements on previous years including partners being able to stay after birth and ensuring parents feel their concerns are taken seriously alongside improvement opportunities including mental health support and choices of where to give birth Midwifery Directorate. The Committee **NOTED** recognised the context of the snapshot survey and that it will be triangulated with other area of feedback and actions will be incorporated into the Maternity Improvement Plan.

Patient Safety

At the January meeting the Committee **NOTED** the Q2 Patient Safety Incident Reporting (due to the challenge of data validation). The Committee noted that there are emerging themes within moderate and severe harms are lost to follow up/treatment and mental health care and treatment in acute settings. There are rises in incident relating to falls, pressure damage, and in addition physical assaults on staff and restraint that are reflective of acute mental health crisis presentations on hospital sites. The category of Staffing was the top theme of moderate severity rated incidents. The Committee welcomed the analysis of harms in the report. The Committee **NOTED** work taking place around Safer Staffing working with the People Directorate and the work from the Deputy Chief Nurse (workforce) reviewing all ward establishments with acknowledgement that acuity and dependency had been changing.

12 Patient Safety Incident Investigations had been raised (including 1 wrong site injection Never Event) of these 12, 1 maternity case was referred to Maternity and Newborn Safety Investigations (MNSI). While the Trust had fully transitioned to the new investigation and reporting framework in, 13 legacy pre-PSIRF Serious Incident investigations had been submitted to the ICB Quality Team and 9 were closed.

The Q2 Duty of Candour (DoC) Report was received, and the Committee was assured by detailed compliance monitoring with the 3 elements of the candour processes. While the Trust has very high compliance for the first 2 elements and is focussing on the third element of feeding back on investigations and discussion of reports with family. The Committee heard about the work to improve the quality of Regulation 20 Duty of Candour compliance reporting, including: the new DCIQ incident module revised data collection tools, with templates collaboratively designed with stakeholder and divisional support; Patient Safety and Duty of Candour Training (mandatory) was being implemented on the IRIS e-learning platform in Q2 2024/25.

The Committee remains assured the quality and safety learning infrastructure is working cohesively and the Q2 report outlines the vigilance of ensuring the learnings are monitored across the safety domains (Safety, Mortality & Morbidity, Structured Judgement Reviews, Complaints, Friends and Family Feedback etc.) It was pleasing to hear the related Trust safety bulletin with the Theme of the Week had been the most read of all UHSussex communications.

The Committee also received a report on Inquests and prevention of future death (PDF) notices and how the learning is fed back into Divisions. The Committee **NOTED** the continued impact of the increase in the number and duration of inquest proceedings, particularly those with significant media profile, were having on staff and providers of the support being given. The Committee discussed the need to review the support needed given the change in profile of inquests and plans to develop confidence and resilience through senior and medical staff. The Committee acknowledged claim and inquest complexity, and costs continued to rise and this reflected a national phenomenon.

<u>Quality Assurance</u>
The Director of Clinical Effectiveness supplied a Quality Assurance report that indicated the current status of NICE guideline reviews, Technology Appraisals, National audits participation and assurance on changed practice and quality improvement for patients, NCEPOD, Clinical guidelines GIRFT review and action plans, Mortality reporting / Learning from Deaths. It was NOTED the focus through Q4 will be on the mandated audits with a comprehensive review provided with 71% of audits being on tracks and the 19 at risk having plans being put in place to progress these. In many cases there had been personnel capacity issues or data issues. The Committee heard how audit prioritisation plans for 25/26.

The Committee examined the engagement challenges faced with clinical audit and understands the issue is competing operational pressures, especially while aspects of the process are more time consuming in data handling than should be needed and work was taking place with Divisional Quality & Safety Directors in this area and developing Division forward plans for 2025/26. The Committee followed up on previous requests for assurance around Sepsis escalations. The Committee heard of the work to ensure a consistent policy and process to fully audit against, overseen by the deteriorating patient group and Sepsis subgroup with the updated policy expected by my next report.

The Committee **NOTED** the outlier reports received including the Hip Fracture Database and heard this has prompted work to focus on areas aligning differential pathways recognising PRH is a national exemplar. Another outlier was the National Early Inflammatory Arthritis Audit (NEIAA) where there had been poor adherence to NICE QS33 on time to treatment from referral. The Committee took confidence from the approach taken by which this was an audit area the Trust had not previously participated in but had returned to it to recognise and address the area of risk. The Committee welcomes the improvement and is **ASSURED** key risk areas are now known.

The Committee **NOTED** that reviews of 100% of Technical Appraisals had been completed and the target of having 75% of NICE guidance reviewed within 90 days continued to be met and had improved 10 percentage points since quarter 2 and noted the slight decline in guidelines assessed as fully compliant due to check and challenge being applied, the Committee took some assurance this reflects rigor in the process. The Committee was encouraged by the reported progress in digitising some of the processes toward using power BI by Q1 2025 that also enabled the streamlining of the baseline assessment process. The Committee understands the opportunity for improvement by added digital alignment and the rollout of electronic patient records (EPR) in the coming years.

The Committee **NOTED** the update on the arrangements for the Trust's Palliative and end of life care aligned with the Learning from Deaths (LFD) process including Structured Judgment Reviews and the Committee **NOTED** the continued work to better understand how deaths can be prevented with the mortality surveillance group starting in March and better identifying opportunities to recognise end of life care needs to improve the patient experience. The Committee examined the arrangements by which experiences in the patient journey are captured by medical examiners through family contact and the context of SJRs as a recognition there is a factor worthy of further investigation.

In respect of Getting it Right First Time (GIRFT) the Trust remained subject to considerable inspection and work to support that programme with steering groups. The Committee heard about fortnightly meetings on progress and monthly oversight of the 'further faster' (top 5) actions overlaid with SIP and CQC actions. The Committee continues to await an update on the governance for GIRFT and how other areas within GIRFT are being undertaken but understood the operational reasons why this is delayed.

The Committee also **NOTED** the timetable for the production of the Trust's Quality Accounts.

<u>Safeguarding</u>

In January, the Committee received the Q3 Safeguarding Children and Safeguarding Vulnerable Adults reports for 2024/25. The Committee **NOTED** the progress on specialised Level 3 training and work taking place with Divisions to broaden uptake of this training and having passed 78.8% the risk register entry had been reduced. The plan is to achieve 85% compliance by end of year. Q3 had seen reduced numbers of patients with primary mental health needs staying in the RSCH emergency department and the Safeguarding team are well sighted on their stay in the department. The committee were updated on the challenges relating to the care of Children and young people with mental health needs and long stays whilst waiting for care. Protracted stays waiting for appropriate care setting remains an extremely significant challenge as highlighted on the Board Assurance Framework and the Committee supports the efforts to convene a System level Summit to ensure effective NHS and local authority partner working, I reiterate to the Board the significance of ongoing risk sharing discussions and persisting issue of vulnerable patients in a non-therapeutic space. The Committee NOTES the extremely challenging work for the Safeguarding team and significant associated costs with the Court of Protection. The Committee was sad to hear about

the notable increase in domestic abuse identified in older people and noted the work with the Hourglass community service that advocates for those needing support.

The Committee welcomes the progress in rolling out the well received communication and interaction training (CAIT) supporting staff to manage distressed behaviour and recognise unmet needs which enables staff to de-escalate situations and may help to retain staff who might otherwise leave if feeling untrained to deal with the increasingly challenging and emotionally impactful work. The Committee was concerned to NOTE that the CAIT trainer contract is due to end and the Safeguarding team hope to make arrangements substantive. The Committee **NOTED** the positive maternity service developments in the area of perinatal mental health.

Quality Impact Assessments

In December, the Committee received an update on the quality impact assessments (QIAs) completed for the 2024/25 efficiency programme. It was agreed the QIA process would be reviewed and **BROUGHT BACK** as an update in the next quarter so that the Committee can be assured and agreed to refer this to audit committee as an area Internal Audit may wish to review.

Care Quality Commission (CQC) action plans

The Committee reviewed the outstanding actions from previous CQC reports and further discussed the approach to the appropriate status recording. Additional scrutiny and oversight given to this area and the 28 MUST do and 11 SHOULD do actions from 2023 as the remaining Must-do action from 21/22 was **NOTED** and the evolution of monitoring through the revised arrangements of the Single Improvement Programme (SIP) Committee which report to the Board. The Committee received the report compliance status for the purpose of ongoing assurance.

The Committee **NOTED** there were 10 overdue actions and following the diagnostics that had taken place for remaining areas of outstanding, specifically, the Medicines Management and Management of Equipment were recognised as longer term periods of work and the Committee will continue to seek assurance through deep dives. The outstanding 2021/22 CQC 'must do' action has shown progress with a policy on cancellation of rebooking of surgery patients now completed. 90 actions had been marked complete and the Committed noted the arrangements by which some actions moved to routine business. The Committee was **ASSURED** of Divisional Engagement through the steering group attendance and thanked Leanne McClean for her leadership and support. The Committee **NOTED** the CQC inspection report from their visit to Worthing Hospital remained considerably delayed with no indication of its arrival. In the meantime, the Committee welcomed the patient safety team's local return to the information requests to pre-emptively review arrangements to assure progress in relevant areas, added to the work from the Deputy Chief Nurse (Quality) and the Worthing Hospital Nurse Director on inpatient mental health arrangements.

Facilities and Estates

In response to the increasing number of risks and issues that had been raised linked to facilities and estates, with quality impacts, at the January meeting, the Chief Finance Officer as executive lead for Estates and the Director of Estates and Facilities tabled a report identifying the surveyed scale of backlog maintenance work required with key areas of priority and that is used to inform the capital plan. The Committee NOTED the focussed work toward bringing all sites up to at least Condition B but recognises the scale of critical infrastructure (electrical infrastructure, heating systems, internal fabric as well as water & ventilation) as part of the backlog work. The Committee NOTED the compliance dashboard maintained by the Estates team and learning through other reports to this Committee will be used through the maturing 'Division Improvement Group' arrangement in Estates with stakeholder input referencing the success of similar improvement group work in Maternity. The Committee recognised the scale and significant impact

that this area has on the Trust asked for a clear articulation of the governance arrangements and links to the health and safety, finance and clinical forums as well as the communications with the hospital workforce to be brought to the next meeting.

Infection Prevention and Control (IPC) Quarterly Report

At the January meeting, the Committee received the IPC report containing the validated data from Q2 2024-25. The Committee noted the Trust had remained above trajectory MRSA , E.coli, P.aeruginosa and C. difficile although E.coli and P.aeruginosa are within tolerance levels and Klebsiellas are below target. Information from the national epidemiology commentary suggests this aligns with the national picture. The Committee **NOTED** the IPC action plan linked to the CQC arrangements and NOTED the work of the ICP team including responding to an endoscopy decontamination incident related to an external provider and also more recent excellent responses to M.Pox incidents and a pan-drug resistant case of Staphylococcus aureus. The team had also worked with division governance meetings to ensure continued focus on surgical site infection risks as well as organism alerts and the report incorporated Division reporting.

The Committee highlights the importance of ensuring consistent basic IPC precautions and **NOTED** the work training multi-disciplinary infection prevention champions. The Committee remains concerned about inconsistency in hand hygiene data between IPC observed scores and division reporting such that assurance cannot be taken but welcomed the update that confirmed how the IPC team had been identifying and changes to the reporting that prompts Division and IPC follow-up on misreporting areas. Ventilation remains a concern and significant work in a multi-year programme continues and I note the Finance & Performance Committee gave consideration, following my referral in Q3, to the Capital plan arrangements that capture the level of quality risks relating to ventilation systems when reviewing the Capital Programme and the agility of the capital programme to respond to these risks.

From the November meeting, the Committee sought updates on issues relating to ventilation and water and for the Estates and Facilities Director to update on management actions in relation to the internal audit relating to Medical Devices which remains an outstanding action. The Committee was pleased to hear that some water testing issues had been resolved that had meant the Haematology Oncology service can operate from the RSCH Courtyard building.

Perinatal

At each meeting the Committee **RECEIVED** reports in respect of the Trust's Perinatal Quality Surveillance Reports & Dashboards for all four of its maternity units, which included the Ockenden data sets within the current dashboards and this has continued to show the perinatal mortality rate sustained below the national average.

The Committee **NOTED** peri-natal mortality and brain injury rates remain below both regional and national rates (noting that the national benchmarking is from 2022). The Committee **NOTED** the contents of the reports and **APPROVED** the latest scorecards that are provided to the Board.

The Committee considered each of the dashboards across each of the domains of; learning from incidents; training; and the voice of the service user. The Committee **NOTED** it had been another challenging period operationally and that there continued to be clear triangulation with staff engagement and feedback. The Clinical Operating Model for the Division had been confirmed to have been funded with recruitment of obstetric clinical directors and two substantive Heads of midwifery. Through receipt of reports the Committee was **ASSURED** that the Maternity Directorate continue to report Maternity and Neonatal data and engage with Maternity and Neonatal Safety Investigation team (MNSI) as required. The Committee

RECEIVED investigation reports within the meeting pack and welcomed their inclusion as well as confirmation of full compliance with the saving babies lives care bundle. The Committee praised the work to ensure filling of key positions and rotas and continued work to understand and address sickness absence was **NOTED**.

The Committee also received the Q2 report on Avoiding term admission (ATAIN) rates which were met for Worthing and St Richards but not for RSCH and PRH and it was noted that a key factor remained the estate issues impacting ability to provide transitional care on site.
The Committee also noted the pleasing MBRACE progress and heard an update from the assurance visit in January with recommendations that had been reflected in the Maternity Improvement Plan. The Committee heard about the good progress being made around a restorative programme and support to families who experience baby loss.

The Committee received updates on progress towards the Trust's year 6 CNST Maternity Incentive Scheme submission and **NOTED** the Board had approved the Submission at their meeting in December.
The Committee received an update on the Maternity Safety Support Programme and the agreed actions for exiting the programme. The Committee **NOTED** the **ESCALATION** that a solution had not been found for theatre access for C-Sections. The Committee sought assurance that theatre access is being addressed at all levels and will look to further updates from the executives through the next quarter.
In analysing maternity health inequalities, the Committee heard how the Trust was engaging with the MSSP support on site level data as recent analysis had been challenging based on extremely small reference data.

Health Inequalities
There has been considerable work to prepare the Trust's progress in this area and the Committee received a detailed report at the December meeting on the Health Inequalities Profile and Improvement Plan. This is based on the NHS Confederation Board Assurance Self Assess to include in Board Strategy identification of those groups and backgrounds disproportionately represented in long waits and poorer outcomes. The Committee heard about Learning from Death analysis and work with Public Health to improve access to data to cross reference. The Health Inequalities Profile provided an overview and assurance of the Trust's position in relation to understanding and taking positive action to reduce health inequity and inequalities, with the outline of an improvement plan. Key areas have been analysis of Referral to Treatment (RTT) and Outpatient waiting time had reduced for all groups of individuals, recognising the longest waits had been recorded for those living in deprived areas and within ethnic minority groups. The Committee welcomed the growing understanding of factors behind this and the plan outlined the Trust's long-term mission for Health Inequalities for the next 2 to 3 years, including, developing a "waiting well" programme to ensure patients are optimised for care when they reach the treatment date, expanding the smoking cessation programme to inpatients, and a focus on key areas of data collection, empowering staff to ask questions and maximise opportunities to collect data alongside work to prepare for the Electronic Patient Record.

Deep Dives
At the December meeting the Committee had a deep dive into **Mental Health** challenges as mentioned above. The Committee is ASSURED by clearer governance and oversight of mental health in the trust, and better understanding of the challenges faced by partners in their systems. However, unprecedented pressures on the mental health system in the NHS and social care remain. The Committee welcomed updates from the CYP Mental Health Project Group that set out their key priorities and areas of focus.

In December we also had a Deep Dive into both **Medicine Divisions** that presented a detailed quality report including patient experience and safety implications and the approach to disaggregating the risks so

they can be tackled and how the Divisions had been learning from each other in clinical governance arrangements and addressing key common issues. The Committee sought to understand challenges reported with the issues raised through the Friends and Family Test Reporting and received **ASSURANCE** about the arrangements, including engaging the Division with new tools, from the Patient Experience Director in January

The Committee also took a deep dive into the **Surgical Divisions** that provided a joint report to the Committee in November. We **NOTED** the report reflected significant improvement across the Surgery divisions with leadership teams working cohesively and noted the key risk themes, JAG (endoscopy) accreditation position and staffing challenges, alongside their positive progress in complaints management and Fundamental Standards of Care audits.

These deep dives enable the committee to understand the challenges and risks faced by the Divisions at a more granular level and importantly triangulate this with the standard reports received by the committee to gain assurance. As Chair I take the opportunity to visit the Divisions presenting to gain first hand insight into the achievement and challenges and to talk to staff to triangulate the reporting received.

Risks and Board Assurance Framework (BAF)

The Committee reviewed the Trust's key risks with the potential to impact on quality and noted those with the highest current score and their alignment to the areas that the Committee had continued to scrutinise for assurance. The Committee recognised a increase in the highest scoring risks which reflected a disaggregation of some long standing risks to reflect the risk of patient harm and unacceptable patient experience from prolonged crowding in emergency departments on each hospital site and improved detail of the controls and actions to mitigate these risks.

In relation to risk 1.1, the Committee heard that we are unable to deliver or demonstrate a continuous and sustained improvement in patient experience, in particular due to the challenging situation arising from crowding in the Emergency Departments and waits for treatment resulting in adverse reputational impact, and poorer patient experience. The Quarter 4 scores remain at 20 as it had remained through 2023/24. There is still belief this could reach the agreed target but this was contingent on improved emergency care performance and patient experience.

The Committee had a discussion on the BAF and the respective risks it has assigned oversight, these being risks 4.1 and 4.2. The Committee reflected on the information received during the meetings in respect of these risks along with the update provided. The Committee supported the continuation of both 4.1 (Unable to deliver any safe and harm free care) and 4.2 at 20 unable to demonstrate compliance with any regulatory and quality standards which is supported by the gaps in compliance noted in my report and updates on incident themes, harm free waiting times.
The work improving the steering group on 4.2 for oversight was **NOTED**.

The Committee also recommended that 4.1 remains at 20. The Committee **NOTED** the executive's reduced confidence that the risk score could reach the 16 target by year end in light of the breadth of actions required and emerging challenges. The Committee **AGREED** with the assessment this appears extremely challenging and noted the risks that underpin this. The Committee **NOTED** that the year had seen considerable improvement in understanding risks through patient safety, patient experience, clinical outcomes and effectiveness and QGSG with the Divisions and recognised significant improvements (for example position around NICE implementation). The Committee looks forward to the refresh of the BAF for 2025/26 in reference to the Trust's strategic plans and priorities.

Quality Governance Steering Group (QGSG) and Quality Scorecard

The reports from QGSG included divisional summaries, as well as safety and quality domain summaries plus updates against the CQC action plans. Since the November meeting, the Committee has NOTED the considerable increase in GIRFT activity in divisions.
Additional reports had come through QGSG on Harm reviews and updates on regulatory compliance risks around Trust Mortuary facilities. Work was reported on each site while RSCH has particular estate risks. I visited the Mortuary and recognise the challenges with difficult estate decisions to be made. The Committee was encouraged by developments with partners to expand one of our hospitals' capacity to help alleviate pressure on other sites. The committee will receive an update on this at the end of Q4.
Detailed reports had also been received via QGSG around Medicines and the QGSG Chair highlighted key issues with work to address around controlled drugs storage and aseptic units, primarily capacity and pharmacy workforce issues. The Committee was ASSURED by good oversight given to reports around End of Life care, Blood transfusion and Resuscitation reports.

Reflecting on the Risk Register update and division reports to the QGSG the Committee **NOTED** the top risk themes had not changed. The Committee understands the risk around the lack of infusion capacity that is a challenge across all sites and affecting every division. The Committee heard QGSG is working to understand demand and delivery models.

Referrals to other Committees

At the December meeting I made a **REFERRAL** to the Audit Committee to invite their consideration of the Quality Impact Assessment process as an area suitable for Internal Audit in the next audit plan.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference.

The Board is invited to **NOTE** that the Committee will undertake a 'deep-dive' at the next meetings focussed on the medical device and equipment arrangement and medicines management given the status of CQC 'must do' actions and in light of the risk and issues indicated in other papers to the Commtitee.

The Board is asked to **NOTE**:

- The Committee's recommendation in respect of BAF risks 1.1, 4.1 and 4.2 for which it has oversight, that the scores for the end of quarter 3 are fairly represented.

The Board is also invited to **NOTE** the following items were received and are commended to the Board:

- Maternity CNST Y6 Submission to note the progress of our submission
- Perinatal Quality Surveillance Update (to receive and note)
- ATAIN & Transitional Care (to receive and note)
- Patient & Quality Learning from Deaths Q2 (to receive and note)

COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	**26 November 2024**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**17 December 2024**	**Chair**	Lucy Bloem	**Quorate**	Yes
Meeting Date	**28 January 2025**	**Chair**	Lucy Bloem	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Focus, Operation and Priorities of the Committee						
QGSG reports	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer/ Dep. Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted.
Quality Dashboard (excluding Maternity) Safety, Effectiveness, Experience, Mortality	**Nov**	**Dec**	**Jan**	**Presenter** Chief Medical Officer/ Deputy Chief Medical Officer	**Purpose** For information	**Outcome /Action taken** Noted.
Patient Experience Report Assurance Report Q3 Quarterly Report-Dec 2024			**Jan**	**Presenter** Director Patient Experience & Engagement	**Purpose** For information	**Outcome /Action taken** Noted
Safe, Effective, Caring, Well Led and Responsive						
Patient Safety Assurance Report - Harm free care Report Counter Measure Summary - Harm Reduction Report - Inquest Monthly Report			**Jan**	**Presenter** Chief Nurse / Deputy Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Infection Prevention & Control Assurance Q2 2024/25 Report			**Jan**	**Presenter** Deputy Director Infection, Prevention & Control	**Purpose** For assurance	**Outcome /Action taken** Noted.
CQC Update / Action Plans	**Nov**	**Dec**	**Jan**	**Presenter** Chief Nurse / Director Patient Safety & Learning	**Purpose** For information	**Outcome /Action taken** Noted
Safeguarding Adults and Children 2023/24 Q2 and Q3 Reports	**Nov**		**Jan**	**Presenter** Chief Nurse/ Deputy Chief Nurse	**Purpose** For assurance	**Outcome /Action taken** Noted.
Divisional Spotlights: Surgery/Critical Care (all sites) (Nov) Medicine/ED RSCH/PRH & Medicine/ED SRH/WH (Dec),	**Nov**	**Dec**		**Presenter** Division Directors of Quality/ and Director of Nursing	**Purpose** For information	**Outcome /Action taken** Noted
Quality Assurance Report Including Clinical Outcomes & Effectiveness Group Reports			**Jan**	**Presenter** Chief Medical Officer / Director Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted

Facilities and Estates Ventilation, Water and Medical Devices updates Backlog Maintenance Report tabled at January meeting	**Nov**		**Jan**	**Presenter** Director Estates and Facilities/ Chief Finance Officer (January)	**Purpose** For information	**Outcome /Action taken** Noted. Work to address issues and compliance dashboard shown
Health Inequalities Profile & Improvement Plan	**Nov**			**Presenter** Chief Strategy Officer / Director Clinical Outcomes & Effectiveness	**Purpose** For assurance	**Outcome /Action taken** Noted
Deep Dive - Mental Health		**Dec**		**Presenter** Chief Nurse / Chief Medical Officer	**Purpose** For assurance	**Outcome /Action taken** Noted.
Perinatal Quality Surveillance Report and Dashboards (Sep-Nov 2024 data)	**Nov**	**Dec**	**Jan**	**Presenter** Director or Midwifery / Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
CNST Maternity Incentive Scheme Year 6 Declaration (to December 2024) Position briefing to November	**Nov**	**Dec**		**Presenter** Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Claims Scorecard Q2 2024/25	**Nov**			**Presenter** Director of Midwifery	**Purpose** For information	**Outcome /Action taken** Noted
Perinatal Mortality Review Tool (PMRT) Q2 2024/25 (Annual Report to December)	**Nov**	**Dec**		**Presenter** Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Maternity Patient Safety Outcomes Report inc Serious Incidents Q3 2024/25			**Jan**	**Presenter** Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Foetal Wellbeing / Saving Babies Lives Review Quarterly Report Q2 2024/25		**Dec**		**Presenter** CNO/ Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Avoiding Term Admissions into Neonatal Units (ATAIN)/ Transitional Care Quarterly Report Q2 2024/25			**Jan**	**Presenter** CNO/ Director of Midwifery/ Chief of Women & Children Service	**Purpose** For information	**Outcome /Action taken** Noted
Risk						
Trust Risk Register relating to Patient & Quality (* Summary of changes only, between Quarterly meetings)	**Nov***	**Dec***	**Jan**	**Presenter** Chief Medical Officer / Chief Nurse	**Purpose** For information	**Outcome /Action taken** Noted
Board Assurance Framework			**Jan**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed risks fairly stated

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the risk score for BAF risks 1.1, 4.1 and 4.2 to the Board for quarter 4 2024/25. The Committee received Patient Experience Quarterly Reports and the Annual Inpatient Survey The Committee received the Infection Prevention and Control Quarterly report The Committee received the Safeguarding Quarterly Report The Committee received the Patient Safety Incident & Duty of Candour and Medico-Legal Quarterly Report The Committee received the Medicines Management Quarterly Report
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
▪ Medical Devices Internal Audit and Management Response (February 2024) ▪ Endoscopy Accreditation (JAG) Action Plan (April 2025) ▪ Plan for Health Inequalities Reporting (Quarter 1 2025/26) ▪ Reasons for decrease in SSNAP scores and challenges to be included in the Specialist Quality Review report (February 2025). ▪ Quarterly Quality Impact Assessments summary to be provided to the Committee to provide evidence and assurance of the QIA process and highlight escalations where necessary (Quarter 1 2025/26). ▪ Update of the Committee sub-group reporting structure and oversight arrangements.
Items referred to the Board or another Committee for decision or action

Item	Date
The Quality Committee invites the Board to **NOTE** the following: The Committee's recommendation in respect of BAF risks 1.1, 4.1 and 4.2 for which it has oversight, that the scores for quarter 4 are fairly represented. The Board is also invited to **NOTE** the following items were received and are commended to the Board: - Maternity CNST Y6 Submission to note the progress of our submission - Perinatal Quality Surveillance Update (to receive and note) - ATAIN & Transitional Care (to receive and note) - Patient & Quality Learning from Deaths Q2 (to receive and note)	**Feb 2025**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	15.	**Meeting:**	Trust Board in Public	**Meeting Date:**	06 February 2025
Report Title:	People & Culture Committee Chair's Report				
Sponsoring Executive Director:	Paul Layzell, Non-Executive Director				
Author(s):	Paul Layzell, Non-Executive Director				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	Yes	People Risks 3.1 and 3.2
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The People and Culture Committee met on the 26 November 2024 also had a further meeting on 28 January 2025. The Committee was quorate as both meetings as was attended by at least two Non-Executive Directors and two Executives Directors. In attendance at these meetings were the respective report presenters including the Director of Workforce Planning & Deployment, Director for Integrated Education, and the Associate Director of Leadership, Culture and Development.

At these meetings the Committee received its planned items including reports from the Freedom to Speak Up Guardian, Guardian of Safe Working Hours, and an update on the Trust's Cultural Programme along with the Employee Relations activity report, the health and wellbeing programme update along with the year 3 priorities for approval. The Committee also received for approval the developed Volunteer Strategy, with the meeting receiving the Chief People Officer's overview report drawing out the focus of the meeting's papers and the Trust People Scorecard Metrics.

The key areas of focus at the Committee are listed below, noting the full breath of the meeting's activity is included in a table at the end of this paper.

People Performance Overview Report.

The Committee at each of its meetings continued to **receive** this report allowing it to consider the focus of the papers at the meeting and receive an overview of the Trust's people metrics. The Committee noted the key messages in the report, aligned to scorecard data and focused its attention on the dip in staff engagement, which was seen in the prior reporting period, with further detail being provided as to the specific elements where reduced engagement has been recorded. The Committee noted the People Scorecard which reflected key workforce indicators covering retention and turnover and STAM performance remain positive along with appraisal rates which remain stable are noted the focus to improve the overall levels by targeting those areas which have the lower levels of attainment.

The Committee noted the continuing trend of reduced engagement levels, reflecting that as winter staff anxiety increases which could be a driver for the continued levels of reduced engagement, but recognised the work undertaken to support staff wellbeing which is seen with a strong level of staff retention. The Committee noted this supports the move in BAF risk 3.1.

Compliance Assurance Framework

The Committee at its November meeting **noted** the developing framework which to complement the safety Compliance Assurance Framework. The Committee was updated on the framework's development and how this is being used by the Trust to secure assurances from various sources including management or internal audit to enable visibility of the adequacy of people processes.

People Plan update

The Committee in January **received** a report on the Trust's progress against its People Plan for 2024/25 which had been constructed around the National People Promises. The Committee reflected on the work being undertaken within this area to learn from national exemplar organisations and were confident over the Trust's commitment to learn and improve. The Committee discussed the need to ensure improvements were well communicated within the Trust.

Freedom to Speak Up Guardian report

The Guardian report provided information on activity, concerns raised and that the Guardian informed the meeting that there was nothing significant and that timely action was taken in respect of all matters raised. The report contained a number of improvement recommendations to enhance the Trust's processes, the Committee **endorsed** that these actions be weaved into the improvement action plan along with actions from the assessment of the Trust's processes against the national report.

The Committee at its November meeting obtained **assurance** from the Guardian that the Trust's processes are understood and accessible to staff and that concerns raised have been addressed and the service and the guardian are well supported by the Trust.

The Committee at its January meeting received the report providing information on the actions being taken flowing from the recommendations made by the Guardian service in their first full year with the Trust. The committee chair also reported on his positive recent meeting with the Guardian aimed at triangulating their observations with the Guardian's data and reports received from elsewhere within the Trust – a key theme being the power of direct, two-way communication. The Committee was **assured** over the actions taken.

Guardian of Safe Working Q3 report

The Committee in its November meeting received a report from the Guardian of Safe Working detailing the continue processes to receive and address any reports from the resident doctors. The Committee was

assured over the work of the guardian and the Trust's processes for dealing with any reports noting there were no significant safety concerns raised.

Improving the lives of resident doctors

The Committee's attention at its November meeting, was drawn to the work undertaken by the Trust and the value the implementation of the Trust's e-rostering system has brought to resident doctors and the Committee noted that the full roll out of the rostering project is to be completed by end of March 2025. The Committee discussed the methods by which the effectiveness of the actions to bring about improvements to residents' doctors and was informed that these are measured through a number surveys including the trainee survey and the national staff survey along with the feedback from Guardian of Safe Working.

Medical Appraisal update

The Committee received an update from the Deputy Medical Director in its January meeting showing the work that has been undertaken across the Trust. The Committee took **assurance** as to the effectiveness of the new medical appraisal processes, noting that the level of medical appraisals had increased over the last quarter to near target level. The Committee also welcomed the same processes being applied to the Trust's locally employed doctors.

Health and Wellbeing Programme

The Committee at its November meeting noted the assurance provided over the management of the programme and the delivery of the year two activities. The Committee agreed the year 3 priorities. The Committee noted the Charities continuing support for staff wellbeing initiatives.

Employee relations

The Chief People Officer provided a report to the November meeting on the number of cases within the last period, with the Committee taking **assurance** that work continues to reduce the length of time to complete the investigations. The Committee discussed the actions taken to secure timely resolution and how the Trust is learning from cases to change policy and procedure and was **assured** that these are tracked as part of the processes. At the Committee's meeting in January the Committee **received** a report on the Trust plan to support managers to make reasonable adjustments to support the Trust's workforce, with clear guidance on the Trust's responsibilities and improved mechanisms for the use of funds to support adjustments.

Culture Update

The Committee **received** an update on the work led by the Chief Culture and Organisational Development Officer. The Committee **noted** the feedback and how this has driven the Employee value proposition for inclusion within the Trust's developing strategy and at its meeting in January the Committee commenced a discussion about the workforce and cultural context to the Trust's 2030 Strategy and agreed to recommend to the Board that it creates time to continue this discussion.

Integrated Education Update

The Committee in its meeting in January received **assurance** that the trainer survey results, like the trainee survey results are weaved in as data points into the Trust's improvement plans.

The Committee approved the terms of reference for a reporting group the healthcare education development group which will provide oversight of the integrated education workstreams.

Voluntary service strategy 2025 – 2030

The Committee considered the developed strategy and that it reflected feedback provided previously to include how this supports the Trust's drive to become an anchor institution. The Committee **approved** the strategy and agreed to share this with the Board for information.

The Committee also received a complementary paper providing **assurance** in respect of the processes over the oversight of volunteers, their recruitment, training and deployment oversight.

Risk Register relating to people and Board Assurance Framework (BAF)

The Committee at both its meetings received and **noted** the key people related risk and at its January meeting considered the People and Culture strategic risks. The Committee discussed the assurance provided to reduce the risk score of strategic risk 3.1 back to its target score and **agreed** based on the assurance provided the reduction was appropriate. For strategic risk 3.2 relating to the Trust's culture the Committee reiterated that whilst work was being undertaken in this area and reported to the Committee and Board it **recognised** that a reduction in score would take longer that this year to achieve. The Committee agreed to recommend these scores to the Board.

Referrals to other Committees

The Committee considered the reports and presentations it received at its meetings and **agreed** there were no matters it needed to refer to any other Committees.

Key Recommendation(s):

The Board is asked to **NOTE**:

The Committee's approval of the Volunteers Strategy and the Health and Wellbeing year 3 priorities.

The Committee's agreement to have six meetings across the 2025/26 year.

The Committee's approval of its reporting group the healthcare education development group.

The Committee recommendation to the Board the score of the two People and Culture strategic risks, risk 3.1 reducing to a score of 12 (its annual target score) and risk 3.2 remaining unchanged.

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COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Details					
Meeting Date	26 November 2024	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

People Performance Overview including People Scorecard	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Utilised the overview to bring focus to the meeting. Noted the recorded performance showing a stable level of performance across the broad range of indicators.
People Compliance Assurance Framework	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Noted the development of the framework and the reassurance this provides on the alignment of assurance provision to the people standards and registrations.
Freedom to Speak Up Guardian 6 monthly report	**Presenter** Freedom to Speak Up Guardian	**Purpose** For discussion	**Outcome /Action taken** Noted, assurance taken over the processes and the level of engagement by the staff. Noted that timely actions were being taken in respect of concerns / matters raised.
Improving the lives of resident doctors	**Presenter** Director of Workforce Planning	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** Noted the improvement actions taken and received an update of national developments.
Health and Wellbeing programme update	**Presenter** Associate Director of Leadership, Culture and Development	**Purpose** For discussion, noting of actions being taken and to agree the year 3 priorities	**Outcome /Action taken** Noted the work undertaken against the current programme. The Committee agreed the health and wellbeing year 3 priorities.
Employee Relations 6 monthly report	**Presenter** Chief People Officer	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** Assurance taken over the work taken in respect of issues raised.

Cultural Programme Update	**Presenter** Chief Culture and Organisational Development Officer	**Purpose** For information and noting of actions being taken	**Outcome /Action taken** Noted and took confidence that the feedback from the work has driven the Employee value proposition for inclusion within the Trust's developing strategy.
Integrated Education Update including GMC national trainer survey results & Library and Knowledge Services annual report	**Presenter** Director of Integrated Education	**Purpose** For assurance	**Outcome /Action taken** Noted the GMC trainer survey results and received **assurance** that the trainer survey results are weaved in improvement plans
Voluntary Services Strategy	**Presenter** Head of Voluntary Services	**Purpose** For approval	**Outcome /Action taken** **Approved** the strategy and agreed to share this with the Board for information.
Updates on Integrated Care System	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** Noted
People Risks update	**Presenter** Chief People Officer	**Purpose** To note	**Outcome /Action taken** The Committee noted these

Meeting Details					
Meeting Date	28 January 2025	**Chair**	Paul Layzell	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting			
People Performance Overview including People Scorecard	**Presenter** Chief People Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Utilised the overview to bring focus to the meeting. Noted the recorded performance showing a stable level of performance across the broad range of indicators.
People Plan 2024/25 update	**Presenter** People Promise Manager	**Purpose** For discussion and assurance	**Outcome /Action taken** Considered the update on the 24/25 people plan priorities and the work being delivered against these. The Committee was assured over the work at the Trust and the Trust's engagement with the wider national exemplar programme and was given confidence that the Trust is committed to bringing wider learning into the Trust.
Payroll performance	**Presenter** Director of Workforce Planning and Trust	**Purpose** for assurance	**Outcome / Action taken** The Committee received a review of the Trust's payroll

	Interim Finance Director		processes and agreed actions following the Trust taking part in a national review. The report provided confidence to the Committee that the actions were targeted against those areas where improvement can be made to both over manual and digital processes. The Committee agreed that further updates on progress would be brought back.
Workforce – Strategic Insights	**Presenter** Chief Culture and Organisational Development Officer	**Purpose** for information	**Outcome /Action taken** The Committee noted the work being undertaken in respect of the people and cultural element of the developing Trust Strategy.
Freedom to Speak Up Guardian recommendations action tracker	**Presenter** Associate Director Leadership, OD and Engagement	**Purpose** for assurance	**Outcome /Action taken** The Committee received the report providing information on the actions being taken flowing from the recommendations made by the Guardian service in their first full year with the Trust. The Committee was assured over the actions taken.
Review of Reasonable Adjustment Process	**Presenter** Head of Inclusion	**Purpose** For discussion and assurance	**Outcome /Action taken** The Committee noted the development of the proposal to support the Trust to better make and apply reasonable adjustments.
Recruitment Deep Dive	**Presenter** Director of Workforce Planning	**Purpose** For discussion and assurance	**Outcome /Action taken** The Committee noted the work being undertaken in respect of recruitment. The update provided gave confidence that the areas of work is aligned to the Trust developing strategy for workforce recruitment and internal progression pathways.
Guardian of Safe Working Hours Q3 report 2024/25	**Presenter** Guardian of Safe Working Hours	**Purpose** For discussion and assurance	**Outcome /Action taken** Noted the improvement actions taken and received an update of national developments. The Committee remained assured over the Trust's processes for addressing any reports made.
Medical Appraisal Update	**Presenter** Deputy Chief Medical Officer	**Purpose** For discussion and assurance	**Outcome /Action taken** Noted, assurance taken over the work being undertaken to progress the levels of appraisal. The Committee took confidence from the positive

			movement made that the Trust would move closer to the nationally better performing Trust's and the established processes have been applied to locally employed doctors as reported they would at a prior Committee meeting.
Cultural Programme Update	**Presenter** Chief Culture and Organisational Development Officer	**Purpose** For discussion and agree any actions required	**Outcome /Action taken** The Committee noted the transitioning of the enabling workstream into the business-as-usual process aligned to the developing organisational development work with the oversight remaining with this Committee.
Integrated Education Update	**Presenter** Director of Integrated Education	**Purpose** For discussion and agree any actions required	**Outcome /Action taken** The committee noted the establish structure and the ToR for the healthcare education development group which would report to this Committee. The Committee approved the establishment of this reporting group.
Updates from reporting groups - JNCC - JLNC - Nursing and Midwifery Group - EDI Committee	**Presenter** Chief People Officer	**Purpose** For discussion and noting of actions being taken	**Outcome /Action taken** The Committee noted the updates and took confidence that there were no specific actions escalated from any of these groups
Updates on Integrated Care System	**Presenter** Chief People Officer	**Purpose** For information	**Outcome /Action taken** The Committee noted the update
People Risks update	**Presenter** Chief People Officer	**Purpose** To note	**Outcome /Action taken** The Committee noted these
Q4 Board Assurance Framework	**Presenter** Chief People Officer / Company Secretary	**Purpose** To review, agree any actions and to recommend to Board	**Outcome / Action taken** The Committee reviewed the document, considered the assurances listed and progress of actions and agreed to recommend to the Board
Committee meeting cadence for 2025/26	**Presenter** Company Secretary	**Purpose** To approve	**Outcome / Action taken** The Committee agreed to have 6 meetings across the 2025/26 year.

Actions taken by the Committee within its Terms of Reference
The Committee **APPROVED** the Volunteers Strategy and **APPROVED** the Health and Wellbeing year 3 priorities. The Committee **APPROVED** the terms of reference for a healthcare education development group which would report to the Committee. The Committee **AGREED** to recommend to the Board that the scores for the Strategic Risks 3.1 and 3.2 were appropriately scored, recognsing that risk 3.1 score is to reduce for quarter 4. The Committee **AGREED** to plan for six meetings across 2025/26.
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
The Committee agreed that it would receive in six months a further update on medical appraisals The Committee agreed in November it would seek assurance that the GMC Trainer Survey results are being fed into Trust improvement plans, this assurance was provided to the meeting in January 2025.
Items referred to the Board or another Committee for decision or action
Item
The Committee agreed there were no specific items referred to another Committee for action. The Committee agreed to provide for information the Volunteer Strategy (which is included as an appendix within the Board pack for information). The Committee agreed to recommend to the Board that it should create time in its workshop cycle to discuss the workforce and cultural strategic context for the developing 2030 Trust Strategy.

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	16.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Finance & Performance Committee Chair's report to Board				
Sponsoring Director:	Bindesh Shah, Committee Member Non-Executive Deputy Chair				
Author(s):	Bindesh Shah, Committee Member Non-Executive Deputy Chair				
Report previously considered by:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	Yes	Assurances in relation to risk 2.1, 2.2 and 2.3
People	N/A	
Quality	N/A	
Systems and Partnerships	Yes	Assurances in relation to risk 5.1, 5.2 and 5.3
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement

Communication and Consultation:

Executive Summary:

The Finance & Performance Committee (FPC) brings together matters within the Trust's Patient First Sustainability and Systems & Partnerships Domains and has met in November and January. Each Meeting was quorate, and the January meeting was a full quarterly committee and covered all areas within the FPC's remit and received, discussed and noted the expected papers that are listed behind this report.

The papers related to the Trust's Sustainability True North, Breakthrough Objective (productivity), Strategic Initiative (environmental sustainability) and Corporate Projects, a Quarter 3 finance report, the Efficiency Programme, the Capital Programme, Operational Performance including the performance against constitutional standards, Commercial team activities including procurement, an ICS finance update and discussion of key risks with the Board Assurance Framework. At the January meeting, the Committee did not receive the planned update on the 3Ts Benefits realisation programme with this deferred to February.

Investment decisions were also considered and approved (subject to the Committee's delegated limits). A number of investment cases were received in November concerning the removal of Reinforced Aerated Autoclaved Concrete (RAAC) with welcome support from NHS England to address these areas. The

Business Case to enable the Colorectal Cancer Surgery to move some aspects of the service to Worthing was also approved.

True North Financial Performance Report - Quarter 3 2024/25 Financial position

At each meeting, the FPC received a report from the Chief Financial Officer/ and interim Financial Director on the financial position against the Trust's Deficit financial plan. The report showed that the Trust had month on month and year to date adverse variance against the plan.

The FPC discussed and **NOTED:**

- As at month 9 the Trust incurred a £46.11 million deficit year to date, and had received £19.47million deficit support funding leaving a deficit of £26.64m, adverse to plan by £15.09million.
- At month 9 the in-month performance was £4.49 million adverse to the plan, consistent with months 7 and 8 and if similar month on month deficit performance is delivered in the remaining months of 2024/25, Year-end outturn is forecast to be £40.4million based on receipt of £31.5million ERF funding
- The enhanced grip and control measures enacted following quarter 1 have continued to slow run-rate increases and considerable non-recurrent items have been applied to the position.
- The most significant in-month and year to date drivers of the adverse position to the plan remain: medical vacancies and costs of premium cover, high cost drug expenditure in excess of the block contract, lower MSK income, the net impact of unfunded change to Insulin Pump usage resulting from NICE guidance, and open escalation beds above the funded capacity.
- There is a very high risk that projected financial outcomes of the efficiency initiatives in delivery will not meet the planned improvements required to achieve the agreed (and funded) £19.5 million full year deficit. With inclusion of recovery plan opportunities, the programme is now identified in full.
- The month 9 efficiency programme under delivered by £5.36 million against plan as the phasing of the efficiency programme had increased for the second half of the year, £10.8 million behind the required year to date delivery. There remains considerable focus from both system oversight and internally on the value delivered associated with the growth in staff establishment since 2019/20. The enhanced grip and control arrangements had led to a reduction in whole time equivalents worked across the Trust, however the pay bill had continued to increase. Agency costs remain below the agency ceiling but are still prevalent in hard to recruit and challenged specialities.
- The Cash position is below plan. Deficit support funding had been received in October. Cash management remains a key area of focus as the year progresses and further cash support is sought.
- The better payments practice code performance is below the target level although performance has been maintained in quarter and the FPC was provided with assurance local small enterprises did not suffer detriment.

At each meeting, the FPC spent considerable time discussing the financial position and recovery plans and discussed and **NOTED**:

- Work on financial improvement and recovery continued the in the previously reported areas:
  - Stabilising the financial position, preventing further deterioration with enhanced spend controls.
  - Bridging the gap in the financial position – with Trust wide Financial Recovery Workstream opportunities evaluated and implemented with support from the efficiency team.
  - Addressing the underlying deficit - undertaken as part of the strategy development work.

Further opportunities discussed in the January meeting include a review being undertaken of all contracting and commissioning cost pressures irrespective of the source.

The Committee noted the governance arrangements for close oversight of the key issues through the Financial Recovery Delivery Board chaired by the CEO and a Cash focussed sub-group of the Committee

Capital Investment Progress Report Quarter 3

The FPC **RECEIVED** the Q3 update against the Trust's 2024/25 capital plan and the forecast outturn.

The FPC **NOTED:**

- The current programme is underspent by £15.4 million year to date but was **ASSURED** this is driven by timing differences and that the full £92 million funds available will be spent in year.
- The risk associated to the timing risk of the delivery of the project to connect to the Worthing Heat Network has been overseen by the Capital Investment Group Monthly meetings with oversight of the Chief Financial Officer. This remains the primary basis for the underspend. The Director of Estates and Facilities reported to the committee on progress in managing the risks to the grant funding timescales. The project must be complete by August 2025 to meet contractual obligations and an associated paper will be prepared for the Trust Board.
- Following considerable mitigation, the planned expenditure exceeds the available funds by £0.78 million (forecast outturn). This overprogramming from the original plan continues to be actively managed through the business case process and the FPC remains **ASSURED** this gives the flexibility required to enable the funds to be spent. A full review of schemes will be carried out in Q4 to review anticipated expenditure to year-end and to identify opportunities to manage the over-programming and delivery of the capital programme within the capital departmental expenditure limit (CDEL).
- The Trust has, with NHSE agreement, deferred some Electronic Patient Record (EPR) funding into the next financial year

ICS Update

The November and January meetings of the FPC **RECEIVED** an update on the Integrated Care System (ICS) financial position, meetings of the Strategy Committees in Common with ICS partners and the proposed system wide work to review how the system improves its services to our population in line with the national initiative to move towards more integrated care, improved prevention and primary care services, reduced health inequalities, better outcomes and a sustainable financial position.

The Committee **NOTED** the Sussex Strategy Committees in Common have their next meeting in early February where there will be discussion of the Priorities areas of work for collective support following the analysis work outlined in the previous report.

Operational Performance

Each meeting the FPC **RECEIVED** a detailed report on the Operational performance of the Trust including the constitutional standards set by NHSE.

The FPC **NOTED:**

- All the performance reports and action plans are subject to significant internal and external scrutiny because of the Tier 1 and 2 oversight arrangements currently imposed on the Trust. The Trust remains in Tier 1 oversight for RTT and Cancer performance and in Tier 2 oversight for Urgent Care.
- Overall Trust performance against all the constitutional standards remained challenging and whilst some progress has been made against targets this has not always been sustained, The Trust was generally below national targets.

- The Trust continues to make good and significant progress on the waiting lists and is sighted on how each is closely managed and the events and situations that gave rise to original waiting list growth are understood. The Committee acknowledged that the profile of the waiting list means the numbers waiting over 65week waits will increase at times as it did in Month 9. The Trust has delivered among the biggest reductions in PTL in England however, it is recognised that the overall position is among the most challenged.
- There are plans to improve performance and acceptance that there is still considerable work to be undertaken. The Trust is engaged with a number of Getting it Right First Time (GIRFT) Visits and planning to embed best practice such that there is an expectation of rapid improvement.

Productivity

Each meeting the FPC **RECEIVED** and discussed an updated report on the productivity breakthrough objective from the Managing Director for Planned Care and Cancer in November and January. The FPC **NOTED** that as of Month 9, year on year the Trust has continued to show one of the largest improvements nationally and significant improvement on the breakthrough objective and activity delivery. Considerable improvement opportunity remains and there are four specialties that require specific focus to deliver efficiently and use less premium spend. There was a detailed discussion around the opportunities to better utilise theatre space across the whole Trust estate and work taking place to consider this in strategic plans.

Commercial Progress Report Quarter 3

The FPC **RECEIVED** a comprehensive report on the commercial activity in Q3 at the January meeting and a report on how the Procurement team will be working with Divisions to understand the implications of new Public Sector Procurement regulations coming into effect in February 2025.

3Ts Benefits Realisation

Due to absence of the SRO and Executive Sponsor, the report to the FPC on Benefits Realisation from Stage 1 was deferred to the next meeting.

Emergency Preparedness Planning and Response (EPRR)

The Committee noted the Annual Report for 2024 from the Emergency Planning Team. The Committee **NOTED** the arrangements in place and improvement actions underway and was **ASSURED** by the findings of the assessment validated by NHS Sussex that the Trust is fully compliant with national standards for Emergency Planning.

Risks and Board Assurance Framework (BAF)

The FPC **AGREED** the reports and discussions accorded with the key risks and their linkage to its oversight of the BAF strategic risks allocated to it triangulated with the reports received. All the BAF risks it has oversight of were reviewed and considered.

Accordingly:

- the quarter 4 2024/25 scores for Sustainability (Finance) risk 2.1 should remain at 20 as indicated by the financial and efficiency reports received; and
- Performance risk 5.1 and 5.2 are fairly represented for quarter 4.

The Committee **NOTED** that it is unlikely that risks 2.1 and 5.2 will achieve their target score by year end but there is confidence that with actions taking place risk 5.1 should reduce to its target risk score. Risk 5.2 is forecast to reduce in quarter 4 but not to its target.

Referrals to other Committees

The FPC considered the reports and presentations it received at each meeting and **AGREED** there were no matters that they wished to refer to other Committees.

Key Recommendation(s):

The Board is asked to **NOTE** the assurances received at the Committee and the actions taken of the Committee within its terms of reference.

The Board is asked to **NOTE** the Committee recommendation that the BAF risks 2.1, 5.1 and 5.2 for which it has oversight, are fairly represented for Quarter 4.

FINANCE & PERFORMANCE COMMITTEE HIGHLIGHTS REPORT TO BOARD

Meeting Date	**28 November 2024**	**Chair**	Philip Hogan	**Quorate**	Yes
Meeting Date	**30 January 2025**	**Chair**	Bindesh Shah (deputising)	**Quorate**	Yes
Declarations of Interest	No declarations were raised				

Items received at the Committee meeting

Sustainability True North Financial Performance Report Quarter 3 2024/25 - Updates Provided in Nov 2024 for Month 7	**Nov**	**Jan**	**Presenter** Chief Finance Officer	**Purpose** For assurance	**Outcome /Action taken** Noted position and significant key risks.
Efficiency & transformation Programme. Efficiency Report Quarter Quarter 3 2024/25 - Updates Provided in Nov 2024 for Month 7	**Nov**	**Jan**	**Presenter** Chief Finance Officer / Efficiency Director	**Purpose** To inform the committee on the update on the 2024/25 plan delivery	**Outcome /Action taken** Noted. There is considerable challenge given escalated phasing of plan since Month 5 and impact of winter pressures
Capital Investment Progress Report Update on Capital Plan for 2024/25		**Jan**	**Presenter** Director of Capital Planning	**Purpose** To update on the implementation of the 2024/25 capital plan & set out actual position at Q3 end.	**Outcome /Action taken** Noted. Overprogramming had reduced and there had been work to significantly mitigate the risk of underspending against the plan. Worthing Heat Network is now the main area of slippage. To Board
ICS System Update Report		**Jan**	**Presenter** Chief Finance Officer/ Chair of Committee	**Purpose** For information	**Outcome /Action taken** Noted system work on financial gap, and national context and the implications for the Trust. Also update on Committees in Common
Commercial Progress Report Q3 2024/25 including Procurement Update		**Jan**	**Presenter** Commercial Director	**Purpose** To Note	**Outcome /Action taken** Noted the activity undertaken by the commercial directorate and upcoming areas of opportunity. Implications of new Procurement regulations were noted
EPRR Annual Report 2024		**Jan**	**Presenter** MD	**Purpose** To Note	**Outcome /Action taken** Noted
Systems & Partnership True North Operational Performance ▪ Performance Scorecard ▪ Report on Constitutional Standards		**Jan**	**Presenters** Director of Performance and BI / Managing Directors	**Purpose** For information	**Outcome /Action taken** Noted and recognised the performance challenges which support the strategic risk score remaining at 20
Investment Decisions & Contract Recommendation SRH Mortuary (RAAC) Roof Replacement (includes temporary build)	**Nov**		**Presenter** Chief Finance Officer/ Director of Capital Planning	**Purpose** To Approve temporary build and Roof works	**Outcome /Action taken** Approved temporary mortuary build. Also Approved roof works subject to receipt of an expected MOU from NHS England .

Investment Decisions & Contract Recommendation SRH Same Day Emergency Care (SDEC)	**Nov**		**Presenter** Chief Finance Officer/ Director of Capital Planning	**Purpose** To Approve	**Outcome /Action taken** Approved. The Committee Noted there is scope to add to this business case should funding opportunities emerge
Investment Decisions & Contract Recommendation Worthing Hospital West Wing Plant Room (RAAC) Roof Replacement	**Nov**		**Presenter** Chief Finance Officer/ Director of Capital Planning	**Purpose** To Approve	**Outcome /Action taken** Approved subject to receipt of an expected MOU from NHS England to enable RAAC works to be completed
Investment Decisions Colorectal Cancer Surgery (relocating some surgery activity from RSCH to WH)	**Nov**		**Presenter** Chief Finance Officer/ Director of Capital Planning	**Purpose** To Approve	**Outcome /Action taken** Approved Business Case. Noted HOSC and ICB support. Noted a cost pressure that executives consider can be mitigated to zero.
Trust Risk Register relating to Finance and Performance		**Jan**	**Presenter** Chief Finance Officer / Company Secretary	**Purpose** For information	**Outcome /Action taken** Noted that the key risks were discussed in Committee and aligned appropriately with the BAF. Future report format to consider.
Board Assurance Framework		**Jan**	**Presenter** Company Secretary	**Purpose** For agreement	**Outcome /Action taken** Agreed risks fairly stated and unchanged for Q4. Noted confidence in reducing risks 5.1 and 5.2 by year end which would mean 5.2 would achieve its target

Actions taken by the Committee within its Terms of Reference
The Committee **AGREED** to recommend the quarter 4 score for BAF risks 2.1, and in relation to risk 5.1 and 5.2 for which it has oversight, are fairly represented. The Committee considered and **APPROVED** business cases and contract approvals within its authority limits
Items to come back to Committee / Group (Items Committee / Group keeping an eye on)
Revised Green Plan to come back as routine item following the NHS England changes to requirement 3Ts Stage 1 Benefits Realisation.
Items referred to the Board or another Committee for decision or action

Item	**Date**
The FPC **RECOMMENDS** that the Board **NOTE:** ○ The Committee considered the quarter 3 score for BAF risks 2.1, and in relation to risk 5.1 and 5.2 for which it has oversight, are fairly represented as at the end of quarter 3. ○ In respect of risks 2.1 and 5.2, there is little confidence that these will achieve their target score by year end. Q4 Actions are forecast to reduce risk 5.1 to its target score	**February 2025**

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	17.	**Meeting:**	Trust Board in Public	**Meeting Date:**	06 February 2025
Report Title:	Committee Chair's Report from Single Improvement Plan Committee meetings				
Committee Chair:	Paul Layzell – NED and SIP Committee Chair				
Author(s):	Paul Layzell – NED and SIP Committee Chair				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	Yes	The SIP is to secure assurance that the Trust's systems support enhanced patient experience
Sustainability	Yes	The SIP complements the oversight of the Trust's use of resources
People	Yes	The SIP is to secure assurance that the delivery of this programme is aligned to the Trust's people plan
Quality	Yes	The SIP is to secure assurance that the Trust's systems support the provision of high quality care
Systems and Partnerships	Yes	The SIP is to support the provision of assurance from the Board to external stakeholders
Research and Innovation	N/A	Not directly

Link to CQC Domains:			
Safe	N/A	Effective	N/A
Caring	N/A	Responsive	N/A
Well-led	Yes	Use of Resources	N/A

Regulatory / Statutory reporting requirement

The Trust Board has entered into a number of undertakings with NHS E and the Board has established robust oversight over the delivery of those undertakings through the dedicated Single Improvement Plan (SIP) Committee. The Trust is also required to provide assurance of the undertakings delivery, and the SIP Committee is integral to flow of assurance over delivery to the Board to then engage with NHS E and the ICB.

Communication and Consultation:

The Single Improvement Steering group received the workstream updates from their meetings which supports the reporting to this Committee.

Report:

The Committee has met the months of November 2024 and January 2025 and was quorate for each of the meetings as it was attended by at least two non-executives, and at least two executives. In attendance at these meetings were also the Programme SRO and Director of Communications.

University Hospitals Sussex
NHS Foundation Trust

Single Improvement Plan programme update and delivery dashboard

The Committee **received** at each of its meetings, the overall programme update from the executive lead for the programme and **received** the delivery dashboard and workstream delivery scorecards. The Committee **received assurance** from the executive lead of the level of delivery and where items were in progress that appropriate actions were being taken and their delivery has appropriate oversight within each of the workstreams. In support of this the Committee took confidence from the detailed workstream update reports.

At its meeting in January the executive lead took the meeting through each of the workstreams drawing attention to the assurance provided to this Committee through the supporting reports or through to other Board Committees. The Committee discussed progress in taking oversight of the programme into 'business as usual' processes, so that oversight of the assurance and continuation of improvements was made in other committees. It was noted that in some cases, this oversight would be multi-year, such as in the Culture workstream. The Committee **agreed** having the clarity over the relevant Committee responsible for workstream oversight and monitoring delivery indicators would be a significant step forward, but recognized also that some workstreams might map to more than one committee – for example, whilst Cultural change would be a focus for the People and Culture Committee, there are relevant cultural issues when safety issues are considered by the Quality Committee. The Committee **agreed** the need to retain overall delivery reporting to the Board until such time the workstream became embedded into the emerging Trust strategy. The Committee **agreed** a closure report showing the mapping to committees would come to a future Board meeting for them to approve the closure of this specific supportive task and finish Committee.

SIP Strategic Road Map and programme resourcing plan

The Committee **reviewed** the strategic road map which aligned to the delivery dashboard and reflected on the developed resourcing plan. The Committee **agreed** the need for this work to be both aligned with the Trust's work on developing its overall strategy for the next five years and the supporting long term financial plan.

Reconciliation of the Single Improvement Programme and the Undertakings

The Committee at its November meeting received a reconciliation of the overall programme delivery and how this maps to the undertakings. The Committee **endorsed** the next phase of this work that will see the securing of the evidence that maps to the assertions of the completion levels. The Committee **agreed** this item would return to the next meeting in January 2025.

At the January meeting the Committee **received** the report on the action against each undertaking and recognised action taken. The Committee **discussed** the process applied by the Executives in their review of the evidence supporting the action taken. The Committee took **confidence** from the discussion that a robust process was applied in determining the action taken and **agreed** to a subsequent meeting a schedule of evidence supporting those addressed to allow the Board to be provided with a recommendation from the Committee.

Improvement workstream reviews

Complementing the review of the programme delivery dashboard on a cyclical basis the Committee scheduled a **focused discussion** on a specific programme, which for November was Specialised Services Commissioning. The Chief Medical Officer as Executive Lead for this workstream provided an update on the scope of the workstream and shape of the improvement programme and the key improvement activities delivered and those in train within this workstream.

The Committee recognised the level of work undertaken to secure a greater understanding of the Trust's delivery of these services and the governance oversight arrangements established over the quality and

performance of these services. The Committee noted that the undertaking of this work has also supported the Trust's conversations with the ICB as specialised commissioning is moving to them to commission in the near future.

Programme Risk Register

The Committee **received** and **noted** at both its meeting that the programme risk register had been reviewed at the supporting executive steering group. The Committee **reviewed** at its January meeting each of the higher scored key risks and provided feedback based on wider reporting through other Board Committees as they referred a number of these back to the Executive to reconsider as they seek to transfer the risks into the business as usual risk management processes.

Recommendations

The Board is recommended to:-

NOTE the Committee continues to provide oversight to the delivery of the overall programme and has in its November meeting continued to receive a detailed review of one of the workstreams.

University Hospitals Sussex NHS Foundation Trust

Agenda Item:	18.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Audit Committee Chair's Report				
Author(s):	David Curley – Audit Committee Chair				
Report previously considered by and date:					
Purpose of the report:					
Information	Yes		Assurance		Yes
Review and Discussion	Yes		Approval / Agreement		N/A
Reason for submission to Trust Board in Private only (where relevant):					
Commercial confidentiality			Staff confidentiality		
Patient confidentiality			Other exceptional circumstances		
Link to ICB / Trust Annual Plan					
Link to ICB Annual Plan	Yes	Link to Trust Annual Plan	Yes		
Implications for Trust Strategic Themes and any link to BAF risks					
Patient	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Sustainability	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
People	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Quality	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Systems and Partnerships	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Research and Innovation	Yes	The Committee provides oversight of the process supporting each aspect of the BAF			
Link to CQC Domains:					
Safe	Yes		Effective		Yes
Caring	Yes		Responsive		Yes
Well-led	Yes		Use of Resources		Yes

Regulatory / Statutory reporting requirement

There is a requirement to have a functioning and effective Audit Committee. The Audit Committee is established to support the Board in securing assurance over the Trust's governance, risk management and internal controls systems.

Communication and Consultation:

Report:

The Audit Committee met on the 21 January 2025 and was quorate as it was attended by Non-Executive Directors. In attendance were the Chief Financial Officer, Deputy Chief Executive, Chief Strategy Officer, and the Trust's Interim Finance Director, Deputy Director of Finance – operational finance, Company Secretary and Deputy Company Secretary along with the Trust's Internal and External Auditors and the Local Counter Fraud team member. The Chief Nurse attended for the relevant internal audit report in respect of CNST and the Chief Information Officer and Head of Information Governance and Data Protection Officer attended for the Data Security and Protection Toolkit report.

Risk Register and BAF reports

The Audit Committee considered, reviewed and discussed the Trust's BAF report and risk management policy compliance report. The Committee continued to be provided with assurance that the Trust's processes underpinning the active review of the BAF have continued over quarter 3 and support the proposed quarter 4

scores to be presented to the respective oversight Committees. The Committee asked through its membership of the respective oversight committee chair's that each committee for those significantly scored risks that are above their target score challenge the actions being taken to see if any further action can be taken over the forthcoming two months to secure a reduction in their risk scores.

The Committee itself reflected on the increasing level of strategic risks recognising that there is also an increasing level of operational risks being recognised by the clinical and corporate divisions and the Committee agreed to request the Board when it receives the BAF as a whole it considers the implication of the inability to achieve the target score for just over half the strategic risks by the end of the 2024/25 year.

Through the receipt of the risk assurance report the Audit Committee was updated on the progress being made by the Trust on the Internal Audit report on divisional risk management which was provided to the Audit Committee at the last meeting in October 2024.

Internal Audit activity

Internal Audit confirmed that they are on track to deliver their reviews by the end of the year. Through their progress paper, the Committee noted the positive opinions Trust's Fit and Proper Persons system for checking compliance, the Trust's processes supporting the CNST year 6 self-assessment and Divisional Financial Controls. The Committee noted that whilst a positive overall opinion, the recommendations made in respect of the strengthening of consistent application of controls across the divisions, were supporting the strengthening of the 2025/26 business planning processes.

The Committee noted the negative assurance opinion on the Trust's BCP processes which was driven by inconsistent and differing processes applied to local BCP documentation and audit. The Committee noted that Internal Audit had been proactively directed to this area to aid the Trust to secure an objective baseline as the two teams merged. The Committee secured confidence from the update from the Deputy Chief Executive as to the actions being taken that would address the weaknesses identified.

The Committee noted the Internal Auditors follow up report continued to show overall good levels of engagement with Internal Audit to provide evidence of action delivery or a sound rationale for any date changes. The Committee noted that there had been an increase in the number of overdue recommendations where responses were not provided but the Chief Financial Officer provided assurance that the gap in securing of responses would be addresses and this dip had been impacted by staff role changes. The Committee sought assurance be provided ahead of the next scheduled meeting that action had been taken in these 8 cases.

Accounting Policies

The Committee considered the proposed changes to the Trust's accounting policies and the rationale for each change. Following their consideration these were approved.

The Committee also approved the consolidated basis on which the Trust's financial statements should be prepared. These being the continued consolidation of Pharm@sea and MyUHSussex Charity into the main Trust statements.

Data Security Protection Toolkit

The Committee received the report confirming that whilst the assessment criteria had changed significantly for this year, 2024/25, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee noted the Trust's self-assessed levels of compliance against the revised criteria as at December 2024 and the work planed prior to the final submission is by June 2025.

Key Recommendation(s):

The Board is specifically asked to **CONSIDER** when the BAF is discussed, the view of the Audit Committee that the overall level of current risk to the Trust's Strategic Objectives being held within the Trust remains high, alongside a continued increase in the level of operational risks and therefore it implications on the Trust's overall risk appetite.

The Board is also asked to **NOTE**

- The Audit Committee's continued receipt of management assurance over the BAF and underpinning risk management processes.
- The LCFS reporting for Q3 had not identified any significant issues
- The level of positive assurance provided by Internal Audit.
- That the Audit Committee approved the LCFS work plan for 2025/26
- The Audit Committee approved the Trust's accounting policies and the continued basis for the preparation of consolidated financial statements for the year ending 31 March 2025

University Hospitals Sussex NHS Foundation Trust

COMMITTEE ACTIVITY HIGHLIGHT REPORT TO BOARD

Meeting	Meeting Date	Chair	Quorate
Audit Committee	21 January 2025	David Curley	**Yes**

Declarations of Interest Made

There were no declarations of interest made.

Matters received at the Committee meeting

Item	Presenter	Purpose of the paper	Action Taken
Internal Audit Reports - Activity Progress Report - Recommendation Follow Up Report	BDO (Internal Auditors)	For assurance over respective areas of internal control	The Committee noted the positive opinions on the Trust's Fit and Proper Persons system for checking compliance, the Trust's processes supporting the CNST year 6 self-assessment and Divisional Financial Controls. The Committee noted the negative assurance opinion on the Trust's BCP processes which was drive by inconsistent and differing processes applied to local BCP documentation. The Committee was informed of the actions being taken that would address the weaknesses identified supported by the Internal Audit confirmed that they are on track to deliver their reviews by the end of the year. The Committee noted the Internal Auditors follow up report continued to show overall good levels of engagement with Internal Audit to provide evidence of action delivery or a sound rationale for any date changes. The Committee noted that there had been an increase in the number of overdue recommendations where responses were not provided but the Chief Financial Officer provided assurance that the gap in securing of responses would be addresses and this dip had been impacted by staff role changes.
Board Assurance Framework (BAF)	Company Secretary	For review and discussion to consider any referrals to other Committees for their	The Committee discussed the BAF and continued to receive assurance that the underpinning processes remained in operation over quarter 3

		oversight of actions and current scores.	and supported the proposed quarter 4 scores which would be scrutinised and approved by the respective oversight committees. The Committee asked through its membership of the respective oversight committee chair's that each committee for those significantly scored risks that are above their target score the challenge the actions being taken to see if anything further can be undertaken over the forthcoming two months to secure a reduction in their risk scores. The Committee itself reflected on the increasing level of strategic risks recognising that there is also an increasing level of operational risks being recognised by the clinical and corporate divisions.
Risk Management Policy Compliance Report	Deputy Company Secretary	For assurance over Trust's process.	The Committee noted the impact the Executive Led Risk Oversight Group has had on the level of risk reviews undertaken. The Committee noted the action taken in delivering the actions recommended by Internal Audit in the report over the divisional risk management processes.
Counter Fraud Reports - Activity Progress Report - Counter Fraud Plan for 2025/26 - Procurement proactive exercise	RSM (LCFS)	For assurance over respective areas of internal control and for information on the Trust's fraud profile and links to LCFS work	The Committee noted the work undertaken by the counter fraud team, that there were no elevated fraud risks. The Committee in receiving the report from the local proactive exercise covering the Trust's contract management and due diligence processes was provided with confidence on the Trust's systems and noted that all improvement recommendations have been agreed. The Committee noted the draft Counter Fraud Risk Assessment, and that one area was proposed for improvement relating to improving the training offer to staff. The Committee approved the Counter Fraud work plan for 2025/26

External Audit Update	GT (External Audit)	To note status of the External Audit work	The Committee noted that the 2024/25 external audit work had commenced and that this preliminary work will support the detailed financial statement work plan to be presented to the next committee meeting in April. The Committee took confidence over the Trust processes as External Audit had not identified any elevated risks from this early work. The Committee was informed of some national work being undertaken by GT but were assured this caused no conflict with the external work.
Accounting Polices	Deputy Director of Finance - Operational Finance	To review and approve	The Committee considered the proposed changes to the Trust's accounting policies and the rationale for each change. Following their consideration these were approved. The Committee also approved the consolidated basis on which the Trust's financial statements should be prepared. These being the continued consolidation of Pharm@sea and MyUHSussex Chairty into the main Trust statements.
Trust Standing Financial Instructions and Financial Scheme of Delegation	Deputy Director of Finance - Operational Finance	To review and recommend to the Board for approval.	The Committee considered the updates noting these were primarily due to changes brought about by the implementation of the new procurement act. The Committee following their review recommended these to the Board. The Chief Financial Officer aloe provided the Committee with an update on the work that has been done to adjust the Trust's processes to ensure compliance with procurement act.
Losses, Special Payments and Overpayments Register	Deputy Director of Finance - Operational Finance	To note the report and the assurance it provides over the Trust's processes.	The Committee took assurance from the comparably low level of losses and special payments noting that a degree of data cleansing had taken place in the quarter.

Tender Waiver Report	Chief Financial Officer	To note the report and the assurance it provides over the Trust's processes.	Through discussion the Committee was assured over the processes being applied to support the review of these.
Data Security and Protection Toolkit 2024/25	Chief Information Officer and Information Governance Manager / Data Protection Officer	To note the progress made and receive an update on the Trusts processes	The Committee received the report confirming that whilst the assessment criteria had changed significantly for this year, 2024/25, the Trust has established a process of seeking, validating and learning from the assurances being obtained against the established standards. The Committee noted the Trust's self-assessed levels of compliance against the revised criteria as at December 2024 and the work planed prior to the final submission is by June 2025.
Information Governance Update	Chief Information Officer and Information Governance Manager / Data Protection Officer	To note	The Committee received an update on the work being undertaken by the Information Governance Manager / Data Protection Officer to improve the Trust's policies in this area
Health and Safety Committee Chairs Report	Company Secretary	Provision of information on the activity of this Committee and review of the Committee's view of the Trust's Health and Safety risks.	The Committee noted the assurance provided over the continued meeting of the H&S Committee. The Committee noted the increasing number of specific Trust wide H&S risk assessments that needed to be completed and how not having these assessments added to the overall degree of risk being held by the divisions and the Trust generally.

Actions taken by the Committee within its Terms of Reference

The Committee approved the Counter Fraud work plan for 2025/26.

The Committee approved the Trust's draft accounting policies and the continued consolidation of Pharm@Sea and MyUHSussex Charity into the Trust's main statements for the year ending 31 March 2025.

The Committee recommended the Trust's Standing Financial Instructions to the Board.

Items to come back to Committee (Items the Committee keeping an eye on outside its routine business cycle)	
There were no specific items outside those within the Committee's business plan required to return to the Committee.	
Items referred to the Board or another Committee for decision or action	
Item	**Referred to**
The Committee recommended the Trust's Standing Financial Instructions to the Board	Board
The Committee agreed to request specifically that as the Board considerers its view that the overall level of current risk to the Trust's Strategic Objectives being held within the Trust remains high alongside a continued increase in the level of operational risks and therefore its implications on the Trust's overall risk appetite.	Board

University Hospitals Sussex
NHS Foundation Trust

Agenda Item:	19.	**Meeting:**	Trust Board in Public	**Meeting Date:**	6 February 2025
Report Title:	Company Secretary Report				
Author(s):	Company Secretary				
Report previously considered by and date:					

Purpose of the report:			
Information	Yes	Assurance	N/A
Review and Discussion	N/A	Approval / Agreement	N/A

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	N/A	Staff confidentiality	N/A
Patient confidentiality	N/A	Other exceptional circumstances	N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	N/A	Link to Trust Annual Plan	Yes

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Patient	N/A	
Sustainability	N/A	
People	N/A	
Quality	N/A	
Systems and Partnerships	N/A	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	N/A	Effective	N/A
Caring	N/A	Responsive	N/A
Well-led	Yes	Use of Resources	N/A

Regulatory / Statutory reporting requirement

Foundation Trusts are required to establish and maintain an effective Board and systems of governance.

Communication and Consultation:

Report:

Staff Governor Election

The election for the staff governor position for the Royal Sussex County Hospital site is underway. The Trust has expressed its thanks to Andy Cook who held this position but following his departure from the Trust this position became vacant.

The deadline for nominations ends on the 4 February. To support of staff members who were considering making a nomination the company secretary has held two drop-in sessions for staff to gain a fuller understanding of the role, 5 staff attended these and the presentations given at these sessions were sent to a further 4 staff who also expressed an interest. The election process is to commence on the 24 February with the election closing on the 14 March with the result being communicated shortly thereafter.

2025-26 Board Meetings

The Trust has reviewed through discussions with both the Board and its Committee the meeting cycles for 2025/26 and below are the Board dates for 2025/26.

8 May 2025	**5 June 2025**	**7 Aug 2025**	**11 Sep 2025**	**13 Nov 2025**	**4 Dec 2025**	**5 Feb 2026**	**31 Mar 2026**

We have yet to confirm the date of the Trust's Annual General Meeting, as the NHS year end timetable for submission of the relevant documents to parliament has not been issued, but we anticipate that we will be able to hold this in early August.

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Recommendations
The Board is recommended to **NOTE** the progress with the Staff Governor election **NOTE** the Board dates for 2025/26

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Trust Board in Public

6 February 2025

APPENDICES

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Agenda Item:	12.	**Meeting:**	Trust Board in Public	**Meeting Date:**	06 February 2025
Report Title:	UHSussex – Maternity Incentive Scheme CNST Year 6 Submission Declaration				
Sponsoring Executive Director:	Maggie Davies				
Author(s):	Emma Chambers, Director of Midwifery Dr Tim Taylor, Chief of Service Hugh Jelley, Director of Operations Claire Hunt, Divisional Director of Nursing Raili Frost, Programme Manager				
Report previously considered by and date:	UHSussex – MIS CNST Year 6 – overview of final position before declaration (Board paper 5/12) Patient & Quality Committee – December 2024 – Recommended for Board approval Trust Board in Private – January 2025 – APPROVED for submission Audit Committee – January 2025 – report noted				

Purpose of the report:			
Information	Yes	Assurance	Yes
Review and Discussion	N/A	Approval / Agreement	Yes

Reason for submission to Trust Board in Private only (where relevant):			
Commercial confidentiality	Yes / N/A	Staff confidentiality	Yes / N/A
Patient confidentiality	Yes / N/A	Other exceptional circumstances	Yes / N/A

Link to ICB / Trust Annual Plan			
Link to ICB Annual Plan	Yes / N/A	Link to Trust Annual Plan	Yes / N/A

Implications for Trust Strategic Themes and any link to Board Assurance Framework risks		
Sustainability	Yes	
People	Yes	
Patient & Quality	Yes	
Systems and Partnerships	Yes	
Research and Innovation	N/A	

Link to CQC Domains:			
Safe	Yes	Effective	Yes
Caring	Yes	Responsive	Yes / N/A
Well-led	Yes	Use of Resources	Yes

Regulatory / Statutory reporting requirement
Maternity Incentive Scheme Clinical Negligence Scheme for Trusts, Year 6 Declaration

Communication and Consultation:
This paper has been prepared for the Trust Board to provide a progress update with regards to the preparation of the Maternity Incentive Scheme (MIS) CNST year 6 declaration – this detail will be first considered by the Quality Committee in December and then be submitted to Board for 9th January 25. The paper comes to the Trust Board with a recommendation for the CEO's signed declaration by both the Trust Chief Executive Officer and Integrated Care Board Accountable Officer. Once complete it must be sent to nhsr.mis@nhs.net **between 17 February 2025 and 3 March 2025 at 12 noon.**

Executive Summary:

Requirement

The MIS CNST scheme supports the delivery of safer maternity care through an incentive element to Trust contributions to the CNST. The scheme, developed in partnership with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Whilst the maternity incentive scheme (MIS) is a self-certified scheme, with all scheme submissions requiring sign-off by Trust Boards following conversations with Trust commissioners, all submissions also undergo an external verification process. Given the Trust's recent CQC inspection and history with CNST evidence, it is possible that NHSR will review our evidence in full too.

Year 6 MIS CNST UHSussex declaration.

Previous reports to the Quality Committee in November 2024 noted, BDO (the Trust internal auditors), undertook the first phase of an assurance audit of UHSussex evidence against current MIS CNST guidance. Their interim report (see appendix 1) provides assurance in support of the Trust's overall declaration. The final audit will take place on 19th December 2024 and the final report will be included for the Board in January.

NHSR require the Trust to submit the year 6 declaration using a self-assessment template. The summary page of this is listed below with the full template including each individual Safety Action tab in appendix 2 along with action plans as necessary. The responses on this template are based on the Trust's ability to evidence compliance against current MIS CNST requirements. Evidence is catalogued against each Safety Action and reviewed by BDO with the latest evidence index included in appendix 3 for reference and stored on corporate folders, available via the Company Secretary. Given that the end of the reporting period was 30/11, evidence is still being collated at time of writing this paper. All outstanding evidence is outlined in red with expected submission dates included for the Committee's information. This will be updated again ahead of the January Board paper submission.

The Board is asked to note that significant progress has been made across all safety actions, with many standards now embedded as business as usual and those areas previously reported at risk, including training compliance, is now delivering in line with MIS CNST standards.

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

Members of the Trust Board will note that the Trust is unable to declare compliance for a sub element of Safety Action 4 – as follows:

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
"Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity:
Locum currently works in their unit on the tier 2 or 3 rota
OR
They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)?
OR
They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility (CEL) to undertake short-term locums?"

Obstetrics and Gynaecology very rarely use agency short term locums unless substantive staff are unable to provide bank shifts. However, the department developed a SOP as part of an action plan to meet the requirements of MIS CNST year 5 and to ensure going forward, processes aligned with RCOG standards. This was signed off for implementation at the end of 2023.

In March, MIS CNST published an overview of changes to the standards, including new automatic non-compliance with Safety Action 4 if any elements above were not met and this had to be based on 6 months of data, specifically Feb 24 to Aug 24.

Throughout the year, both temporary staffing and the department were confident that the SOP had been implemented on all sites, but on review of audit data for Feb-Aug 24, it was found that 1 out of the 3 agency locums engaged during that period, undertook one 12 hour shift on Feb 19th as an ST3

doctor without a CEL (albeit, in the process of completing the requirements.) The doctor was withdrawn from a previous booking because of the non-compliance, but unfortunately the same process was not followed for the second booking request. The agency who provided the locum has been asked to remove any other doctors who do not meet these requirements from short term locum register going forward.

Further, the consultant in charge of the junior doctor rota had requested the locum because he was familiar with them from his previous Trust and was reassured that he was competent to perform the shift and that he possessed the necessary skills. There were also no other internal or external options to cover that shift. There were no safety incidents on this shift.

Since February, no other short-term locums have been engaged without this documentation. However, on review of this issue, further failsafe processes have been added to prevent this from occurring in future, by all parties involved – the agency, Temporary Staffing Office and the Obstetrics and Gynaecology Department (as outlined in the Declaration Form).

The Trust has liaised with NHSR as to the consequences on the declaration given no impact around safety of patients. NHSR have advised to declare non-compliance with an action plan included in the declaration form, and they will put the Trust's case forward for review at the NHSR Collaborative Advisory Group results meeting for consideration for a potential upgrade to compliant, and advocate on our behalf given that all other safety standards have been met.

It is likely the outcome won't be known until the March / April 2025.

Following review and approval of final position, the Trust is required to review and seek sign off proposed declaration with the ICS (21st and 31st January) and submit paperwork including action plans to NHSR **between 17 February 2025 and 3 March 2025 at 12 noon.**

Key Recommendation(s):

Members of the Committee are asked to discuss and agree proposed declaration against the 10 Safety Action Standards. Following the Board meeting on 9th January 2025, the Trust CEO is required to include an electronic signature on Tab D of the MIS Board Declaration Form, (rows 39 to 43) - see appendix 2.

Please note – in the Year 5 programme (2023/24) there was a lapse with regards to Safety Action 1 PMRT (one sub element only – one case report timeframe missed). The Trust declared this, and reported the mitigations in place to address future re-occurrence within the final declaration submission. The Trust received confirmation from NHSR and MBRRACE-UK and was upgraded to compliant in March 2024, receiving £2.2m returned incentive.

Appendix 1 – BDO Interim Audit Report (already received)

Appendix 1 - 2425 MIS Year 6 Evidence Review (UHSx) - Proposed Final Report 1.docx

Appendix 2 – MIS CNST Year 6 Declaration form

Appendix 2 - UHSx MIS_SafetyAction_2025_Protected_V10 1.xlsx

Appendix 3 – UHSussex Evidence Catalogue in support of Year 6 declaration, as reviewed by BDO Audit.

MIS Year 6 audit tool Unlocked for University Hospitals Sussex 20240411.xlsx (evidence index tab)

To note – all outstanding evidence is outlined in red with expected submission dates included for the Committee's information. This will be updated again ahead of the January Board paper submission.

Evidence File Name	Standards Addressed	Evidence description	Named Lead(s)
General evidence			
Board papers	All	Monthly reporting to Board of CNST position	Emma Chambers, Tim Taylor
BDO audit reports	All	Interim and final BDO audit reports confirming Trust's compliance position	Emma Chambers, Tim Taylor
SA1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?			
SA1 reports	1.5	Quarterly reports submitted to Board (Q4, Q1, Q2)	Kate Hasson, Monika Mills
SA1 MBRRACE-UK notification compliance	1.1-1.3	Confirmation from NHSR and MBRRACE-UK re reporting timeframes and compliance (continuous from 2nd April 24 not 8th Dec 23) - relates to X33 and X34 (in spreadsheet) missed deadlines.	Kate Hasson, Monika Mills
SA1 QC papers inc reports	1.5	Quality Committee cover papers inc PMRT reprots	Kate Hasson, Monika Mills
SA1 SC meeting minutes	1.6	PMRT cases discussed and shared monthly with Safety Champions	Kate Hasson, Monika Mills
SA1 PMRT MBRRACE CaseListForYear241211-ID-CNST.csv	1.1	Downloadable PMRT database (note removed patient details). Columns J and K demonstrate compliance. Column U working days included as at 11/12/24	Kate Hasson, Monika Mills
SA1 PMRT MBRRACE CaseListForYear241211-ID-CNST.csv	1.2	Downloadable PMRT database (note removed patient details). Column O (filter out N/A), Column T (filter only yes CNST eligibility), Column X showing 100% compliance as at 11/12/24	Kate Hasson, Monika Mills

SA1 PMRT MBRRACE CaseListForYear241211-ID-CNST.csv	1.3	Downloadable PMRT database (note removed patient details). Column T (filter only yes CNST eligibility), Column (filter only review in standard 'yes'), column X (filter out N/A) showing 95% compliance as at 11/12/24	Kate Hasson, Monika Mills
SA1 PMRT MBRRACE CaseListForYear241211-ID-CNST.csv	1.4	Downloadable PMRT database (note removed patient details). Column T (filter only yes CNST eligibility), Column (filter only review in standard 'yes'), column X (filter out N/A), column AA (filter out not applicable) showing 87% compliance as at 11/12/24	Kate Hasson, Monika Mills
SA1 PMRT Database to 111224.xlsx	1.1-1.4	Internal database to provide failsafe and monitor timeframes	Kate Hasson, Monika Mills
SA1 Reportable Deaths to MBRRACE 111224.xlsx	1.1	Further failsafe after missed notifications (outside of CNST window) created since June 24	Kate Hasson, Monika Mills
SA1 Quality Committee Minutes	1.5 and 1.6	PMRT reports discussed at QC (Board Safety Champs both members)	Kate Hasson, Monika Mills
SA1 December 2023 Stillbirths & Neonatal deaths up to 28 days of life report.xlsx	1..1	December 2023 MBRRACE reporting failsafe	Kate Hasson, Monika Mills
SA2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
SA2 LMNS confirmation standard continuously met Mar 24.docx	2.1, 2.2	Confirmation standards continually met Oct 23-Mar 24	Sally Harborow
SA2 UHSx April Provisional Data.docx	2.1, 2.2	LMNS confirmation of provisional data	Sally Harborow
SA2 provisional June MSDS submission.docx	2.1, 2.2	LMNS confirmation of provisional data	Sally Harborow
SA2 provisional May data.docx	2.1, 2.2	LMNS confirmation of provisional data	Sally Harborow
SA2 provisional July MSDS data.docx	2.1, 2.2	LMNS confirmation of provisional data - standard met	Sally Harborow
SA2 MSDS Compliance received 241024.png	2.1, 2.3	Final published data demonstrating confirmation 24th Oct	Sally Harborow
SA3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?			

SA3 Eml NHSR confirmation re registration of QI project.docx	3.3	NHSR confirmation that Kaizen representation at TC ATAIN steering group can be considered registration.	Julie Carr, Rebecca Elms, Gail Addison
SA3 screenshot postnatal meeting inc Kaizen.PNG	3.3	MZ (Kaizen W&C rep) joins weekly postnatal lead meeting to develop QI A3.	Julie Carr, Rebecca Elms, Gail Addison
SA3 Screenshot Kaizen attendance Sept steering group.PNG	3.3	MZ (Kaizen W&C rep) joins ATAIN TC steering group in Sept and agrees to support A3 development	Julie Carr, Rebecca Elms, Gail Addison
SA3 TC ATAIN audits	3.1	TC audits include evidence of neonatal involvement in care planning (includes evidence of continued reporting to QC and LMNS)	Julie Carr, Rebecca Elms, Gail Addison
SA3 CNST Year 6 - overview and QC sign off requirements.docx	3.2	Board paper including Transitional Care action plan for review	Julie Carr, Rebecca Elms, Gail Addison
SA3 LMNS sign off	3.2	Trans care action plan within LMNS board agenda and minutes	Julie Carr, Rebecca Elms, Gail Addison
SA3 UHS-CG-0016-2023 Admission to SCBU, NNU or TC v1.0.pdf	3.1	Admissions policy including Transitional Care (35-36+6 week)	Julie Carr, Rebecca Elms, Gail Addison
SA3 Transitional Care action plan and sign off	3.1	Transitional Care action plan	Julie Carr, Rebecca Elms, Gail Addison
SA3 Safety champions QI update	3.4	Update on QI given to MatNeo safety champions in October meeting	Julie Carr, Rebecca Elms, Gail Addison
SA3 LMNS update QI update	3.4	LMNS minutes confirming QI project update Nov	Julie Carr, Rebecca Elms, Gail Addison
SA3 LMNS sign off	3.2	Paper, agenda and minutes demonstrating LMNS sign off of BAPM TC action plan	Julie Carr, Rebecca Elms, Gail Addison
SA4: Can you demonstrate an effective system of clinical workforce planning to the required standard?			
SA4 eml forecast 2500 cot days and staffing requirements.docx	4.13	Email from neonatal CD re TMBU cot days forecast and associated staffing.	Cassie Lawn

SA4 anaesthetic rotas	4.12	Rotas for all 4 sites re duty anaesthetist availability - Sept representative month	Roisin Monteiro, Olivia Sherwood, Celia Bygrave, Emily Duckham
SA4 - NHSR RCOG confirmation re short and long term locums	4.1 - 4.4	NHSR and RCOG clarification	Tim Taylor
SA4 Perinatal workforce reports	4.14, 4.19	6-monthly perinatal workforce reports detailing neonatal medical and nursing positions	Tim Taylor, Claire Hunt
SA4 Quality Committee Minutes	4.14, 4.20	QC minutes where neonatal workforce levels are raised, April includes 6-monthly perinatal workforce report	Tim Taylor, Claire Hunt
SA4 Quality and Safety reports - consultant attendance	4.7	Quality and safety reports including consultant attendance audit results and need for action plan to address non-compliance.	Tim Taylor
SA4 standard eml short term locums.docx	4.1-4.3	Standard template from Temporary Staffing incl requirements for CEL.	Tim Taylor
SA4 Long Term Locums OG v2.docx	4.4	SOP developed for Year 5 and implemented into Year 6	Tim Taylor
SA4 Short Term Locums OG v2.docx	4.1-4.3	SOP developed for Year 5 and implemented into Year 6	Tim Taylor
SA4 CNST Year 6 - overview and QC sign off requirements.docx	4.3,4.4 4.8-4.10, 4.13-4.15, 4.18-4.20	Nov board paper inc action plans and outcome of audits	Tim Taylor, Claire Hunt
SA4 Eml NHSR re short term locum non-compliance.docx	4.3	NHSR confirmation to declare non-compliance and await outcome of panel	Tim Taylor
SA4 LMNS sign off	4.9-4.11, 4.15-4.22	LMNS Board sign off of obstetric workforce, neonatal medical and nursing workforce standards	Tim Taylor, Claire Hunt
SA4 QC and safety champion sign off	4.9-4.11, 4.15-4.23	Nov minutes required.	
SA4 KSS ODN CG Minutes September 2024.docx	4.17 and 4.22	ODN Clinical Governance minutes where neonatal nursing and medical workforce returns are received and discussed	Claire Hunt, Cassie Lawn
SA4 agency mitigations - short term locums.docx	4.3	Email confirmation from agency regarding changes to their processes to ensure Doctors without CELs aren't included in their register,	Tim Taylor
SA5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?			

SA5 perinatal workforce reports	5.1	Perinatal workforce reports that go to Quality Committee and Board (Q1 and Q2). Board Minutes Sept - Nov to be included	Beckie Elms, Gail Addison
SA5 BR+ recommendation approval	5.2	BR+staffing recommendations paper plus exec sign off	Beckie Elms, Gail Addison
SA5 PQS dashboard Mar - August.xlsx	5.5	PQS dashboard demonstrating monthly 100% compliance with 1:1 care in active labour across sites. Taken from Badgernet.	Beckie Elms, Gail Addison
SA5 UHSx Maternity Escalation Policy UHSC022.pdf	5.4	Escalation policy - labour ward coordinators must be present at the start of shift safety huddles am and pm	Beckie Elms, Gail Addison
SA5 Quality Committee Minutes	5.1	Quality Committee minutes where midwifery workforce issues are raised. April includes full 6-monthly report.	Beckie Elms, Gail Addison
SA5 UHSx Maternity Escalation Policy UHSC022.pdf	5.4, 5.6	Escalation policy including actions to keep women and babies safe including in times of acute staffing shortages	Beckie Elms, Gail Addison
SA5 red flags - supernumerary status and 121 care	5.4	02/04/24 - 30/11/24 red flags including supernumerary status. Shows loss of supernumerary and providing 1:1 care <1 a week over 29 weeks	Beckie Elms, Gail Addison
SA5 red flags - supernumerary status and 121 care	5.5	02/04/24 - 30/11/24 red flags including maintaining 1:1 care in established labour.	Beckie Elms, Gail Addison
SA5 management actions - escalations	5.4	02/04/24 - 30/11/24 management actions taken across sites in times of escalation	Beckie Elms, Gail Addison
SA5 safer staffing reports	5.6	Apr - Sep safer staffing reports details actions by site to address vacancies and fill rates causing red flags	Beckie Elms, Gail Addison
SA5 PQS dashboard Mar - Sept data.xlsx	5.5	PQS dashboard demonstrating monthly 100% compliance with 1:1 care in active labour across sites. Taken from Badgernet.	Beckie Elms, Gail Addison
SA5 PQS dashboard with clinical indicators UHSx Oct 2024.xlsx	5.5	PQS dashboard demonstrating monthly 100% compliance with 1:1 care in active labour across sites. Taken from Badgernet.	Beckie Elms, Gail Addison
SA6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			
SA6 LMNS assurance meeting minutes and papers	6.2, 6.3, 6.5	Minutes and action tracker from quarterly assurance meetings covering progress against trajectory, QI work	Laura Spicer
SA6 Quarterly reports for QC	6.1	Quarterly reports to QC and Board, as evidence of working towards and achieving compliance QC minutes confirming receipt and review of Q2	Laura Spicer

SA6 updated standard 270824.docx	6.1	Email - NHSR removed requirement for exec MD sign off of SBL if using the tool	Laura Spicer
SA6 LMNS sharing learning and review of themes	6.4	LMNS QSF agendas and minutes documenting SBL related sharing learning and themes regarding potential harms (eg audits, RFM etc).	Laura Spicer
SA6 Quality Committee Minutes	6.1	Minutes where 100% SBL implementation has been shared with QC (Apr, June, July, Aug) Sep-Nov to be included	Laura Spicer
SA6 Board minutes	6.1	Board minutes with SBL report including 100% implementation	Laura Spicer
SA7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.			
SA7 engagement	7.1	Includes: -email train regarding engagement with Trust Developing Communities charity on antenatal education materials	Laura Naish, Laura Spicer
SA7 MVP Annual Work Plan 202425 (12).pdf	7.1	Workplan including work with bereaved parents and working with group who experience poor outcomes	Laura Naish, Laura Spicer
SA7 UHSussex MNVP Meetings 202425 - for workplan_ FINAL.pdf	7.1, 7.2	Perinatal equity and equality meetings, includes new requirements for CNST	Laura Naish, Laura Spicer
SA7 updated standard 270824.docx	7.5	Email - NHSR updated standard re CQC action plan survey to excl narrative if not made available.	Laura Naish, Laura Spicer
SA7 NHSR email comms re MNVP meetings	7.2	Confirmation from NHSR re MNVP attendance at meetings being recommended rather than required for yr 6.	Laura Naish, Laura Spicer
SA7 LMNS review	7.7	LMNS programme board minutes documenting review of CQC survey action plan	Laura Naish, Laura Spicer
SA7 MNVP meeting membership ToRs	7.2	ToRs for MatNeo safety champions, Quality and Safety (inc PMRT reviews), Maternity Improvement Group. Overview of all meetings.	Laura Naish, Laura Spicer
SA7 QGSG-PQC Maternity Report Cover Sheet summary September meetings.docx	7.4	Escalation re lack of resource to have MNVP at monthly PMRT meetings, to be a requirement for next year	Laura Naish, Laura Spicer
SA7 NHSR email confirming PWS escalation re MNVP meeting requirements.docx	7.2	NHSR confirmation to escalate via PQS where resource restricts meeting membership of PMRT	Laura Naish, Laura Spicer

SA7 QC minutes	7.4	May and July QC minutes noting lack of suffucient funding to make MNVP members of full list of Perinatal Governance meetings	Laura Naish, Laura Spicer
SA7 2024.05.23 LMNS Programme Board DRAFT Minutes vF.pdf	7.3	LMNS board approval of MNVP budget for 24/25	Laura Naish, Laura Spicer
SA7 LMNS email confirmation of MNVP infranstructure.docx	7.3	LMNS email update regarding budget and infrastructure	Laura Naish, Laura Spicer
SA7 MNVP annual survey.pptx	7.1	Results from annual survey. 24/25 still underway and results available in 2025.	Laura Naish, Laura Spicer
SA7 UHSussex MVP Vice Chair Job Description & details Nov 23.pdf	7.3	Chair JD - currently being updated.	Laura Naish, Laura Spicer
SA7 UHSussex Maternity Voices_ Trustwide Meeting_ September 2024.pdf	7.1	Quarterly MNVP meeting presentation demonstrating SU engagement in quarter. May's also included in folder.	Laura Naish, Laura Spicer
SA7 Full MNVP Survey Report May 2023-Feb 2024.pdf	7.1	Demographic breakdown of survey	Laura Naish, Laura Spicer
SA7 Eml DoM and LMNS re additional funding.docx	7.4	Email chain between DoM and LMNS Programme Director re additional MNVP funding to enable attendance at PMRT and neonatal governance meetings.	Laura Naish, Laura Spicer
SA7 service user expenses	7.4	Example evidence of service user expenses payments	Laura Naish, Laura Spicer
SA7 2024.09.26 LMNS Programme Board DRAFT Minutes vF.pdf	7.4	LMNS programme board mins documenting review of MNVP survey	Laura Naish, Laura Spicer
SA7 Anon MNVP Feedback Survey responses 22nd March - 4th October 24 (3) - Copy.xlsx	7.1	MNVP survey raw data	Laura Naish, Laura Spicer
SA7 MNVP Equity and equality workstream	7.1	Meeting invites related to perinatal equity workstream hosted by LMNS	Laura Naish, Laura Spicer
SA7 Baby Loss & Bereavement Co Production Project.pdf	7.1	Coproduction project minutes	Laura Naish, Laura Spicer
SA7 Eml MNVP engagement evidence with different groups.docx	7.1	Email from MNVP chair with list of engagement evidence with communities who experience inequalities	Laura Naish, Laura Spicer
SA7 Walk the Patch Demographics - July 2023 - October 2024.pdf	7.1	Demographic breakdown of service users who take part in Walk the Patch exercises	Laura Naish, Laura Spicer
SA7 Matneo Safety Champions review	7.6	Matneo safety champion meeting agenda and minutes (Nov) where action plan was discussed	Laura Naish, Laura Spicer

SA7 CQC survey action plan 2024.xlsx	7.5	Co-develoed MNVP UHSx action plan from annual CQC patient survey	Laura Naish, Laura Spicer
SA7 Reward and Recognition Procedure - CNST.msg	7.3	LMNS confirmation that Reward and Recognition Policy for MNVP will be available at the end of 2024.	Laura Naish, Laura Spicer
SA7 Eml confirmation MNVP to be invited to PMRT.docx	7.2	Confirmation from governance team that MNVP will be invited to PMRT from 2025.	Laura Naish, Laura Spicer
SA7 2024.11.28 LMNS Programme Board DRAFT Minutes.pdf	7.2, 7.4	Additional MNVP funding approval from LMNS board enabling PMRT and neonatal meeting occurrence from early 2025	Laura Naish, Laura Spicer
SA7 Reward and Recognition Procedure Casual Workers November 2024 FINAL.docx	7.3	Reward and Recognition policy - signed off in Dec 2024.	Laura Naish, Laura Spicer
SA8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			
SA8 NHSR confirmation of NLS standard change.docx	8.18	NHSR removal of requirement to have Resus Council UK certified NLS training for neonatal and paediatric staff	Tim Taylor
SA8 IA impact on June MDT training.docx	8.4, 8.5, 8.8, 8.9	IA clash with June MDT skills drills	Claire O'Brien, Jac O'Kane
SA8 impact of general anaesthetist training.docx	8.1	Cost implications to train general anaesthetists	Hugh Jelley
SA8 updated standard 270824.docx	8.3, 8.7, 8.12, 8.16	Email - NHSR updated requirement for rotating medical staff	Claire O'Brien, Jac O'Kane
SA8 - NHSR confirmation bank v agency v NHS professionals compliance.docx	8	in compliance but not agency / NHS Professionals (checked via temporary staffing)	Claire O'Brien, Jac O'Kane
SA8 Eml TMBU PRH NBLS compliance 090924.docx	8.17	Email current compliance TMBU and PRH nurses 09/09/24	Claire Hunt
SA8 WH SRH neonatal nurse compliance OCT 23-OCT 24 - Copy.xlsx	8.17	WH and SRH nurse compliance as of October with plan for end of Nov	Claire Hunt
SA8 RSCH PRH medical inc ANNP Nov compliance.xlsx	8.14-8.16, 8.19	Confirmation from Neonatal CD re medical NBLS compliance	Cassie Lawn
SA8 monthly compliance.xlsx	8	Training compliance by staff group across 3 competencies	Claire O'Brien, Jac O'Kane
SA8 NBLS in house training	8.21	Confirmation from Neonatal CD re NBLS already being BAPM compliant and regular 90% doctor compliance	Cassie Lawn

SA9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?			
SA9 Maternity Claims Scorecards	9.6	Claim scorecards presented to Quality Committee and Board every quarter, via QGSG Q1 and Q2	Emma Chambers
SA9 PQS reports and dashboards	9.1, 9.2, 9.3	PQS reports and dashboards, additional papers inc thematic reviews Nov data to be included when available	Sally Harborow
SA9 LMNS Board QSF minutes	9.1, 9.4	LMNS Board paper agreeing to review PQS model locally by end of Q1 24/25. PSIIs shared and learning	
SA9 listening event action plan updates	9.5	Action plan updates shared with staff via comms MW sent April (March updates), August	Emma Chambers
SA9 Quad and SCs meeting	9.7	Meeting invite (bi-monthly), minutes of meetings, updates in PQS meetings to Board Oct-Nov minutes to be included	Emma Chambers
SA9 Quality Committee Minutes	9.0	Monthly review of PQS report and dashboard (Apr-Oct) Nov data to be included as available	Emma Chambers
SA9 Quality Committee Minutes	9.2, 9.3	Monthly review of perinatal quality and safety presented by Quad (Apr-Aug). Thematic reviews (May), SIs Sep-Nov to be included	Emma Chambers
SA9 Quality Committee Minutes	9.6	Legal claims scorecard triangulation presented April and August Nov to be included	Emma Chambers
SA9 Quality Committee Minutes	9.8	Update re perinatal culture event (action from perinatal leadership and culture workstream. (June)	Emma Chambers
SA9 Safety Champs TOR V1 FINAL.doc	9.2	NED safety champ (Lucy Bloem) included in ToR of monthly meeting	Emma Chambers
4. SA9 Private Board - Minutes - 02 May 2024 vAMc_Redacted.pdf	9.2, 9.3, 9.6	May Board minutes discussing PQSM, PQS report, Maternity Claims scorecard	Emma Chambers
SA9 Private Minutes 01.08.2024vPS Redacted.pdf	9.2, 9.3	Aug Board minutes inc PQSM and thematic review	Emma Chambers
SA9 Overarching PQS report Sep 2024 data - Copy.docx	9.8	Nov PQS report with update on outcomes from SCORE survey	Emma Chambers
SA9 Apr-Nov 24 Maternity Champ Report[15].docx	9.1	NED record of site visits and issues to support and escalate	Emma Chambers
SA9 NED Eml confirming site visit plans Nov Dec	9.1	NED email with plans for remaining 2024 site visits	Emma Chambers

SA9 CNST Year 6 - overview and QC sign off requirements.docx	9.7, 9.8	Board paper outlining Quad and SC meetings and Leadership and Culture workstream updates Minutes to be included	Emma Chambers
SA9 Improvewell updates for staff	9.5	Monthly updates from Improvewell for staff including	Emma Chambers
SA9 Quad and Safety Champion Minutes - November.docx	9.8	Quad SC meeting with item on SCORE survey overview	Emma Chambers
SA9 M5. UHSussex Minutes - Patient Quality Committee 27 August 24 signed LB_Redacted.pdf	9.6	July Quality Committee minutes where Maternity Claims Scorecard is received and discussed	Emma Chambers
SA9 2024.11.28 LMNS Programme Board DRAFT Minutes.pdf	9.3, 9.4	LMNS board minutes approving PSIRF SOP which will inform PQS reporting. Sharing of UHSx LLR.	Emma Chambers
SA10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?			
SA10 DOC template and guidance	10.3	Trust DOC template and recent example inc MNSI and ENS details	Kate Hasson, Monika Mills
SA10 PQS dashboard with clinical indicators UHSx Aug 2024.xlsx	10.4	DOC compliance Apr - Aug Sept-Nov to be included	Kate Hasson, Monika Mills
SA10 PQS reports	10.7	PQS reports for QC demonstrating reporting of DOC compliance and MNSI / ENS qualifying cases Sept-Nov to be included	Kate Hasson, Monika Mills
SA10 Board minutes	10.4, 10.7	May, August Board minutes including MNSI cases and PQSM which include DoC compliance Nov to be included	Kate Hasson, Monika Mills
SA9 CNST Year 6 - overview and QC sign off requirements.docx	10.6	Board paper including DOC template which goes to all families who qualify for statutory DOC.	Kate Hasson, Monika Mills
SA10 Reporting to MNSI	10.1	Confirmation from MNSI that all cases have been reported 2nd April - 30 November	Kate Hasson, Monika Mills
SA10 Eml confirmation ENS and CMS WH SRH referrals.docx	10.2, 10.8	WH SRH legal team confirmation of referring ENS cases to NHSR and using the CMS tool.	Kate Hasson, Monika Mills
SA10 PQS dashboard with clinical indicators UHSx Oct 2024.xlsx	10.4	DOC compliance Apr - Oct data	Kate Hasson, Monika Mills
SA10 Reporting to ENS	10.2	Confirmation from legal teams confirming relevant cases have been referred to NHSR's Early Notification Scheme	Kate Hasson, Monika Mills
SA10 CMS reporting	10.8	Confirmation from legal teams confirming relevant cases have been reported via the Claims Reporting Wizard.	Kate Hasson, Monika Mills

Appendix 4 – Email from NHSR regarding short term locum non-compliance

SA4 Eml NHSR re short term locum non-compliance 041224

RE: CNST SA4 short term locums - query
DS
DUBISON, Selina (NHS RESOLUTION)
To:
FROST, Raili (UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST)
Cc:
TAYLOR, Timothy (UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST);+2 others

Wed 04/12/2024 11:26
Hello Raili,

Thank you for your email. I'm responding on Bridget's behalf (I hope you don't mind), we are receiving lots of queries, so we are sharing the workload.

For MIS year 5, providers were required to ensure that the following criteria were met for employing short term locums.

a. Locum currently works in their unit on the tier 2 or 3 rota?
"OR
b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?"
"OR
c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?"
Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?
"OR
Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings?

At this stage, if providers had not implemented the RCOG guidance of long term locums and were unable to provide assurance or evidence of compliance, the expectation was that an action plan was developed to address any shortfalls in compliance to their Trust Board, Trust Board level safety champions and at LMNS meetings.

Compliance with this sub-requirement within the safety action last year indicates that Trusts have either implemented the RCOG guidance on engaging long-term locums or developed an action plan to address any

compliance shortfalls. The MIS year 6 guidance builds on what Trusts should have already established for MIS year 5 regarding this sub-requirement.
We cannot permit the audit to commence from March 24; it must be conducted from February to August 24, as specified in the guidance.

We would therefore advise the Trust to declare non-compliance with this sub requirement of safety action 4. We recommend that you outline any mitigating circumstances regarding the locum doctor's non-compliance in the action plan tab of the declaration form. This should include a detailed account of the incident as described below, along with the steps taken to ensure future adherence to the RCOG guidance on engaging long-term locums.
If this is the only sub requirement failed for the whole of the MIS year 6, the MIS team will put your case forward for review at the NHSR Collaborative Advisory Group results meeting for consideration for the potential upgrade to compliant. While we cannot guarantee an upgrade, we will ensure that all the details from your board declaration form are provided and advocate on your behalf for a potential upgrade.

I hope this is helpful for you.

Kind regards

Selina Dubison
Maternity Incentive Scheme Associate
selina.dubison1@nhs.net
Landline: 020 3862 6398

NHS Resolution
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From: FROST, Raili (UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST) <raili.frost1@nhs.net>
Sent: 03 December 2024 08:48
To: DACK, Bridget (NHS RESOLUTION) <bridget.dack@nhs.net>
Cc: TAYLOR, Timothy (UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST) <timothy.taylor2@nhs.net>; ADAMSON, Sebastian (UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST) <sebastian.adamson2@nhs.net>; CHAMBERS, Emma (UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST) <emmachambers2@nhs.net>
Subject: CNST SA4 short term locums - query

Dear Bridget,

I hope you're well.

I'm contacting you for advice re Safety Action 4, specifically the CEL requirement for engaging short term locums on middle grade rotas. (I've cc'd th UHSx Chief of Service, CD for Obstetrics and DoM too).

We very rarely use agency short term locums unless our substantive staff are unable to provide bank shifts. However, we developed a SOP to meet the requirements of CNST year 5 to ensure going forward we aligned with RCOG standards. This was signed off for implementation at the end of 2023.

Having reviewed the audit data for Feb-Aug 24, we've discovered that 1 out of the 3 agency locums engaged during that period, undertook one 12 hour shift in February as an ST3 doctor without a CEL (albeit, in the process of completing the requirements.)

The consultant in charge of the junior doctor rota made this decision as he had worked with the doctor at his previous Trust (the Dr in question is a long-term locum at QA in Portsmouth) and was reassured that he was competent to perform the shift and that he possessed the necessary skills. There were also no other internal or external options to cover that shift.

The locum engagement happened in Feb 24, with the SOP just introduced and before CNST Yr 6 guidance was published (pre-dating both the March overview of changes and full guidance in April). Although the audit asks for Feb - Aug data, the requirement change in Year 6 (now resulting in automatic non-compliance), only came in March. Are we able to provide 6 months from March to demonstrate compliance in only engaging locums with a CEL since then?

We had our final MDT training session last week week and now meet all requirements within all other safety actions. I know the teams involved will be hugely disappointed if we fail a standard (and therefore the whole of CNST) because of one shift during a month where there was no guidance available for Year 6.

Any advice greatly appreciated.

Thanks
Raili

Raili Frost
Maternity Improvement Programme Manager
(She/her)
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Email: raili.frost1@nhs.net
Royal Sussex County Hospital, Eastern Rd, Brighton and Hove, Brighton BN2 5BE

NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

Perinatal Quality Surveillance – Trust wide summary report – November 2024 data

Purpose

There are five principles for improving oversight for effective perinatal[1] clinical quality[2] to ensure positive experience for women and their families. They integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

Background

In response to the need to proactively identify trusts that require support before serious issues arise, a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services.

The provider trust and its board, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, remain responsible for the quality of the services provided and for ongoing improvement to these.

Introduction

The Ockenden enquiry concluded that there needs to be more direct Board oversight of Maternity. A suggested dashboard was produced by NHSE/1 which we have adapted for use at University Hospitals Sussex Trust and tested via Quality Board.

[1] In recognition that neonatal services are inextricably interdependent with maternity services, we refer to maternity and neonatal quality in terms of 'perinatal clinical quality' throughout this document.
[2] High quality care is understood, as per National Quality Board (NQB) definitions, to be care that is safe, clinically effective and which provides a positive experience for women. Additionally, in maternity, it is recognised that safe care can only be achieved when care is personalised

This single page data dashboard together with an exception report relating to the metrics is submitted each month to Board for presentation by Emma Chambers, Director of Midwifery, sponsored by Maggie Davies as Maternity Champion at Board level. The surveillance dashboard/exception report will flow through the Monthly maternity Quality and Safety meetings.

Risk Register

There were no new risks added or closed during November with a score of 16 and above:

Escalations for January meeting

- Solution not yet found for separate theatre access for planned caesareans on the Brighton site following successful pilot.
- Heating system in delivery suite theatre at PRH extremely fragile, impacting on access to theatre in emergencies.

Celebrations for January meeting

- Further reduction in perinatal mortality rates, December rates less than half the most recently available national rate.
- Successful recruitment to obstetric and neonatal clinical directors for whole service and permanent heads of midwifery
- Antenatal and newborn screening Quality Assurance visit completed by NHSE on 7th January 2025, no urgent/ immediate actions, evidence quality highly commended, improvement work commended. Some recommendations made; an action plan will be developed.

Domains

1. *Deaths and Harm*

Nov-24	Latest MBRRACE National Figure (June 2023)	Southeast Benchmark (June 2023)	Trust Rates	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Deaths and Harm							
12 Month Rolling Neonatal Death (NND) Rate per 1000 births	1.67 (2.33 for Level 1 NNICU sites including RSCH)	1.4	1.28	0 NNDs 12 month rolling rate is 1.35/1000	2 NNDs 12 Month rolling rate is 2.22/1000	0 NND. 12 month rolling rate is 1.38/1000	0 NNDs. 12 month rolling rate is 0/1000
12 Month Rolling Stillbirth Rate per 1000 births	3.33	3.3	1.16	0 Stillbirths 12 month rolling rate is 1.35/1000	1 Stillbirths 12 month rolling rate is 1.77/1000	0 Stillbirths 12 month rolling rate is 0.92/1000	0 Stillbirths 12 month rolling rate is 0.51/1000

12 Month Rolling Perinatal Mortality Rate per 1000 births	5[3] (5.66 for Level 1 NNICU sites including RSCH)	4.7	2.44	2.7	3.99	2.29	0.51
MNSI Referrals	n/a	n/a	1 x MNSI	1 x MNSI	0 x MNSI	0 x MNSI	0 x MNSI
Serious Incidents (SI)/PSII	n/a	n/a	1 x SI	1 x SI	0 x SI	0 x SI	0 x SI

Maternity and Neonatal Safety Investigation (MNSI) Referrals:

PRH: Cooling case

Maternal Deaths

SRH: Death by suicide 8 months following birth.

Analysis:

Overall, the service continues to demonstrate special cause improvement in neonatal death, stillbirth and overall perinatal mortality rates as well as Hypoxic Ischemic Encephalopathy (HIE or brain injury) grades 2&3. The rates continue to remain below national rates, they are now also below the Southeast benchmark, however, the service continues to progress quality improvement actions previously outlined, which are focused

[3] Update: On 11th July the 2024 the MBRRACE-UK perinatal mortality surveillance, UK perinatal deaths of babies born in 2022: State of the nation report was published. State of the nation report | MBRRACE-UK (le.ac.uk)

The rates using 2022 data for England were as follows:

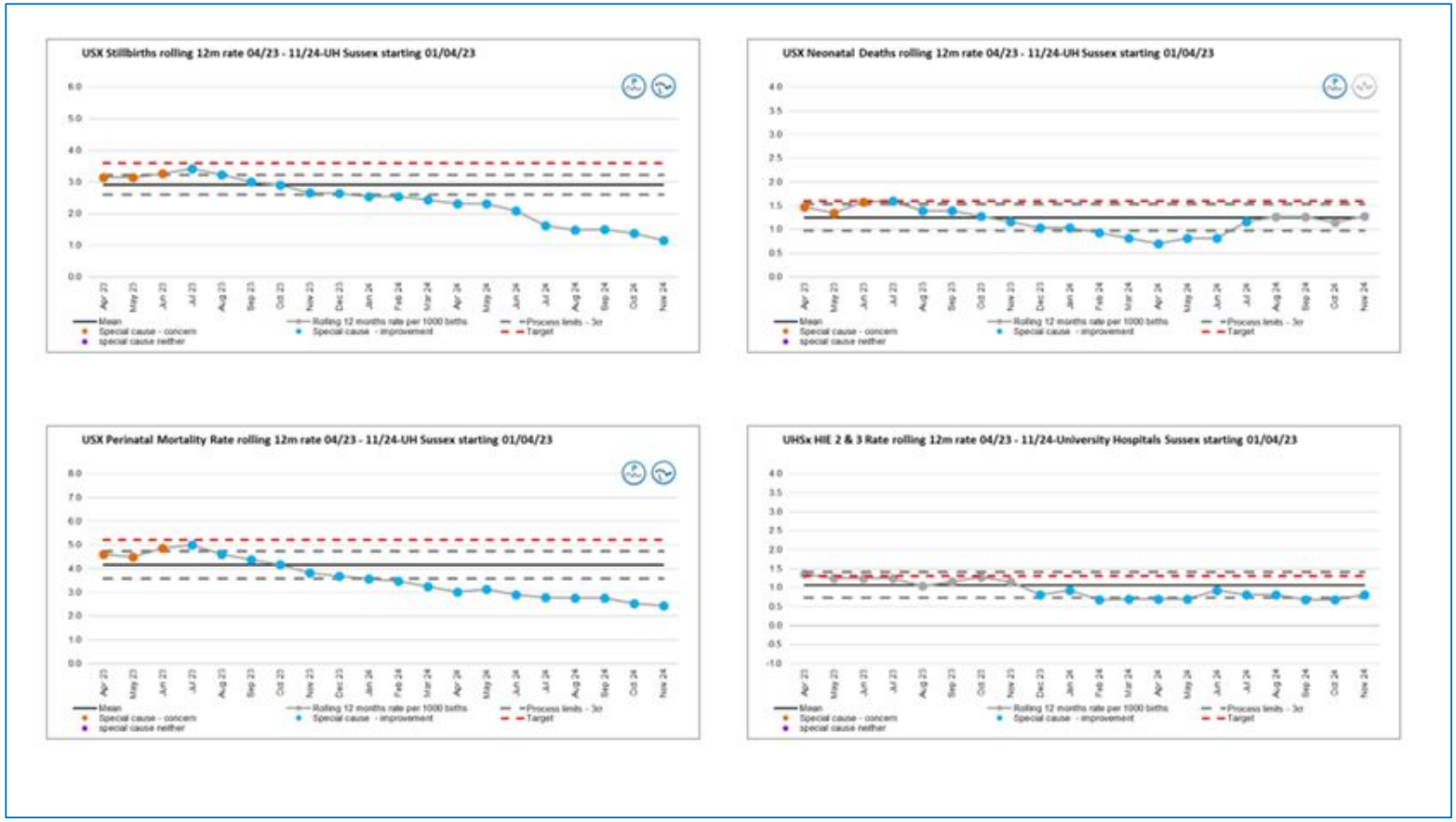
Neonatal deaths: 1.67 per 1000 births

Stillbirths: 3.33 per 1000 births

Perinatal mortality: 5 per 1000 births

on reducing poor outcomes further. These include workforce improvements, training, culture, documentation and fetal monitoring, as well as implementation of the Saving Babies Lives care bundle v3 (SBLv3) which is now fully implemented.

Perinatal Mortality Statistical Process Control (SPC) charts, (using the NHS England SPC tool[4]).



Site Specific SPC charts will be presented next month (quarterly)

[4] Statistical-Process-Control-Tool.xlsm (live.com)

Health Inequalities – Nov 2024 outcome data

Analysis:

	PRH			RSCH			SRH			WH		
	GM	10	20	GM	10	20	GM	10	20	GM	10	20
Stillbirths												
Neonatal Death												
Preterm (<37 weeks)												
Ex Preterm (21+6 - 23+6 weeks)												
HIE 1,2,3												
Smoking at Booking												
Smoking at Delivery												

GM = Global Majority
10 = 10th decile for area of deprivation
20 = 20th decile for area of deprivation

Significant change
Significant Improvement
Significant Deterioration

Out of 84 SPC charts in the grid above, 15 showed significant improvement and 2 showed significant deterioration. It is worth noting however that rare events such as a stillbirth, neonatal death or extreme preterm births will appear statistically significant on the charts, however a pattern cannot be established.

Also, events in the 10th decile for deprivation will also appear in the 20th decile for deprivation, so a standalone event will often appear statistically significant for both groups.

The numbers of service users in the Global majority 10th and 20th deciles for which UHSx provided care during birth for November 2024 as follows:

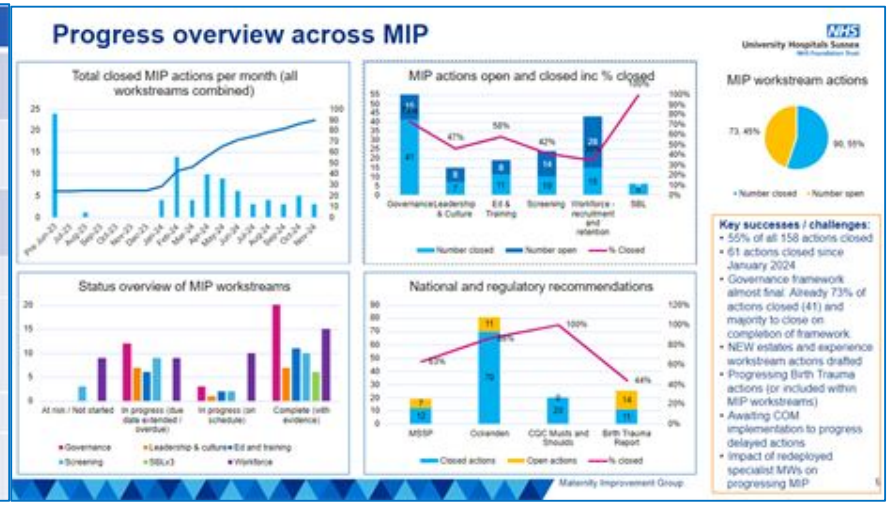
Birthing people	671	
Global Majority	93	13.86%
10th Decile	19	2.83%
20th Decile	76	11.33%

The LMNS have confirmed that set of SPC charts representing the Trust as a whole rather than single sites, should be available for February 2025 onwards.

Maternity Safety Support Programme (MSSP) and Maternity Improvement Plan (MIP):

The service continues to make progress towards achieving the required exit criteria. This was recognised during a review meeting in November. A further review meeting is scheduled for late January, with a view to moving into the sustainability phase of the programme, with the aim for exit mid 2025.

Criteria	Actions required	Estimated completion
Permanent midwifery leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q4 2024/25
Developed Perinatal leadership structure	Clinical Operating Model (COM) finalisation then recruitment	Q3-4 2024/25
Consultant job planning re leadership and governance	Clinical Operating Model (COM) finalisation then recruitment	Q3-4 2024/25
Maternity Governance Framework	Finalisation and ratification	Q4 2024/25
Access to separate theatre for elective caesareans on Brighton site with a view to relocation on other sites.	Successful pilot completed – negotiations with surgery underway	Q4 2024/25
Developed maternity strategy	Discussion with Chief Strategy Officer	Q4 2024/25
Cross site maternity audit plan and guideline group	Central guideline group in place, audit plan in development	Q3 2024/25



Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS):

See accompanying paper

2. *<u>Leadership and training</u>*

UHSx	Skills Drills (inc NBLS)		
Staff group	**All staff**	**In date**	**% compliance**
Obstetric Anaesthetic Consultant	38	35	92%

Anaesthetic trainees (incl trained new starters)	60	55	92%
Obstetric consultants	42	40	95%
Obstetric trainees (incl trained new starters)	52	47	90%
Midwives inc Bank	528	506	96%
Support staff and nurses	164	151	92%
	884	***834***	***94%***

UHSx	**FM (attendance only)**		
Staff group	**All staff**	**In date**	**% compliance**
Obstetric consultants	42	39	93%
Obstetric trainees (incl trained new starters)	33	30	91%
Midwives inc Bank	513	477	93%
	588	***546***	***93%***

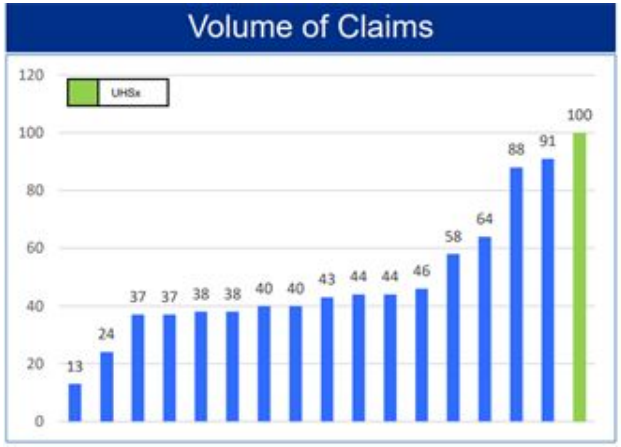
The service achieved the required 90% compliance in all staff groups for the CNST Maternity Incentive Scheme submission by 30th November 2024.

3. Voice of the User

Voice of the user	Princess Royal, Haywards Heath	Royal Sussex County Hospital, Brighton	St Richards Hospital, Chichester	Worthing Hospital, Worthing
Friend and Family Test	100.00%	83.3% - matron reviewing themes	96.67%	90.00%
Complaints	2	3	4	1
Legal Claims	1	1	0	1
MNVP concerns	0	0	0	0

Legal claims benchmarking:

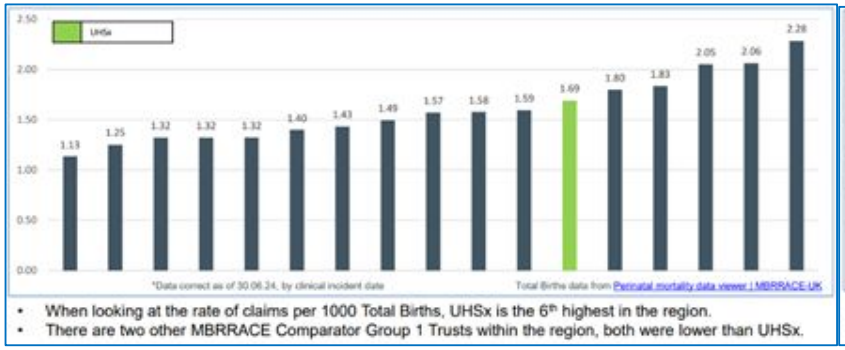
Each year, NHS Resolutions proved the Trust with data regarding paid legal claims against the Trust over a rolling 5-year period. The latest data covers 2017-2022. As the largest maternity provider in the region, the volume and value of claims is the highest in the region. When benchmarking against comparator services with Level 1 neonatal intensive care and neonatal surgical services, the rate of claims is the highest on the three equivalent services, but the value of claims is the lowest, suggesting that there are more claims but with a lower value.



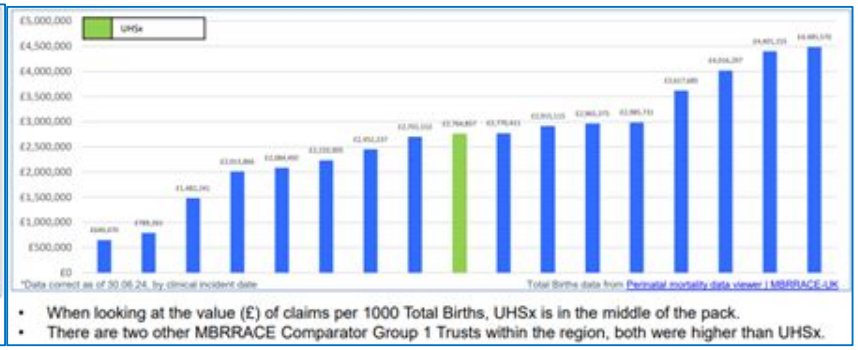
UHSx had 100 (open & closed) claims with an incident date between 2017 to 2022, this was the highest number of claims seen in the SE region.

The Total value of UHSx claims was £163.6M, this was the highest when compared to the other SE Regional Trusts.

Volume of claims per 1000 births and value of claims per 1000 births

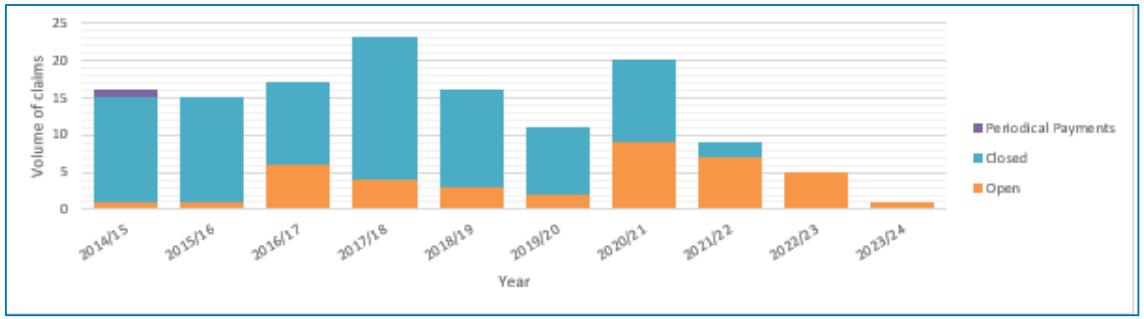


- When looking at the rate of claims per 1000 Total Births, UHSx is the 6th highest in the region.
- There are two other MBRRACE Comparator Group 1 Trusts within the region, both were lower than UHSx.

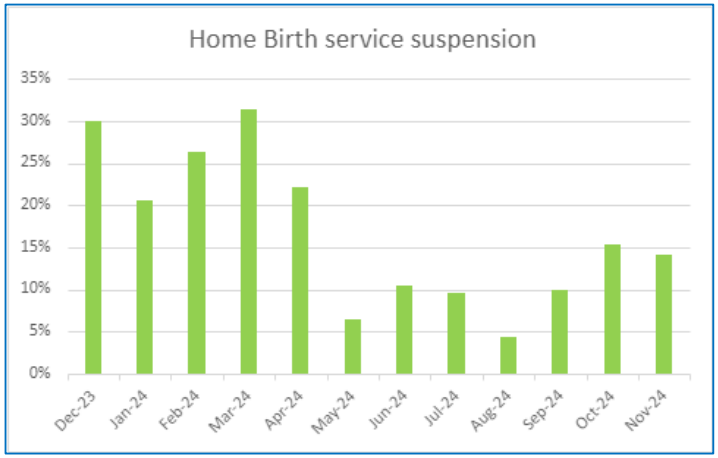


- When looking at the value (£) of claims per 1000 Total Births, UHSx is in the middle of the pack.
- There are two other MBRRACE Comparator Group 1 Trusts within the region, both were higher than UHSx.

The highest reason for volume of claims is ‘failure or delay’ in treatment and the highest value of claims is brain injury. It is known that the lag time for claims is approximately 3 years, therefore, it is difficult to know the impact of the improvement work that has taken place across the service. As previously reported, there is a significant reduction in perinatal mortality and brain injury rates, as well as improved service user experience ratings, there is hope that this will play through into the number of legal claims over the next few years. The service will continue to triangulate legal claims, complaints and incident themes and develop improvement actions each quarter and present to the Board.



Home Birth Suspensions:



Sickness within the home birth and wider midwifery teams has impacted home birth service delivery. Reducing overall midwifery vacancy will positively impact this service over the coming months.

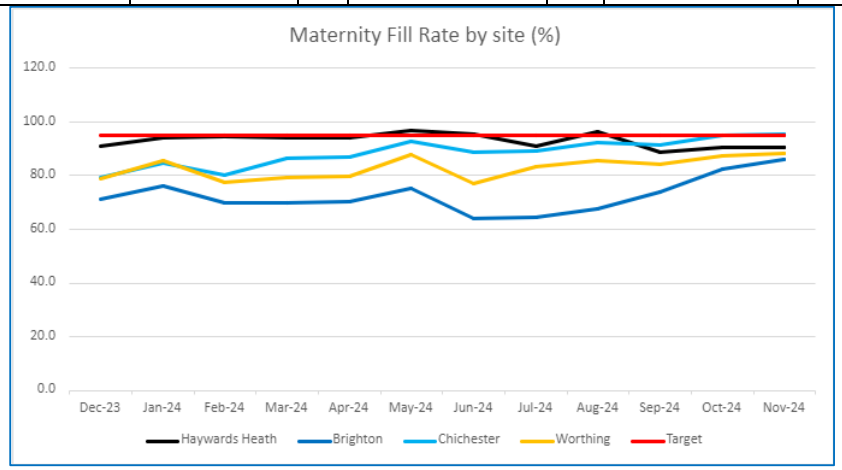
4. Team feedback

Perinatal Workforce

A maternity Safety Forum was chaired by Lucy Bloem, Maternity Safety Champion NED, and Maggie Davies, executive Maternity safety Champion, on 7th January 2024. Discussions included improving staffing, perinatal mortality rate improvements, ImproveWell, request for team to join the Maternity Improvement Plan working groups and the vision and aspirations for the service in 2025.

Midwifery workforce:

Workforce	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		St Richards Hospital, Chichester		Worthing Hospital, Worthing	
Midwifery B5/6/7 core vacancy	2.91%	↓	9.88%	↓	4.21%	↑	9.50%	↓
Midwifery sickness	4.20%	↓	10.60%	↑	7.00%	↓	8.50%	↓
Actual vs planned staffing	90.74%	↑	86.05%	↑	95.53%	↑	88.10%	↑



A reduction in midwifery vacancy rates has resulted in increased fill rates, especially in Brighton. Sickness rates remain high on some sites, targeted action supported by HR, is taking place in these specific cost codes.

Neonatal nursing

	Princess Royal, Haywards Heath		Royal Sussex County Hospital, Brighton		Worthing Hospital, Worthing		St Richards Hospital, Chichester	
Nursing vacancy rate	10.6%	↓	20.2	↓	20%	↓	13%	↓
Nursing sickness rate	8.3%	↑	5.7%	↓	6.5%	↓	5.4%	↓
Parenting leave	8.0%		3.4%		2%		10%	

Active recruitment continues on all sites for neonatal nursing. At our NICU in Brighton a workforce plan to increase nurse staffing numbers incrementally over 3 years is on track. The plan includes an education strategy to improve numbers of QIS trained nurses and to reach the 70% standard for QIS nurses on shift. Nursing numbers in our level 1 SCU's remain fragile due to small teams however this is supported by additional bank work carried out by regular temporary staff and additional hours by substantive employees. Work continues to recruit and retain experienced neonatal nurses. Sickness rates remain high but are reducing on all sites except Haywards Heath, with work ongoing to support the team's well-being and to appropriately manage sickness absence.

Obstetric medical

O&G WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	32.11	26.42	5.69
Medical - SAS Doctor	1.53	1.20	0.33
Medical - Resident Doctors	43.77	41.33	2.44

O&G PRH/RSCH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	24.46	23.24	1.22

Medical - SAS Doctor	2.01	0.00	2.01
Medical - Resident Doctors	34.00	34.93	(0.93)

Twice daily Consultant present ward rounds (Ockenden requirement):

- RSCH – compliance 92% - escalated to Obstetric Clinical Director
- PRH – compliance 90% - escalated to Obstetric Clinical Director
- WH – 100%
- SRH 100%

Narrative information

The consultant workforce WTE deficit has been judged to be due to consultants drawing PAs from external sources within their job plans. The Clinical Director has had reassurances that the RSCH site is now facilitating twice daily ward round 7 days per week. The same can now be said of PRH after a meeting with the outlying consultant who was not present for the evening ward round. As a result, these numbers should be 100% going forward.

Neonatal medical

Paediatrics WH/SRH	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	29.37	29.43	(0.06)
Medical - SAS Doctor	4.22	4.52	(0.30)
Medical - Resident Doctors	40.71	27.53	13.18

Medical team cover paediatric and neonatal services at WH/SRH

TMBU	Budget WTE	Contracted WTE	Vacancies
Medical - Consultants	10.77	14.54	(3.77)

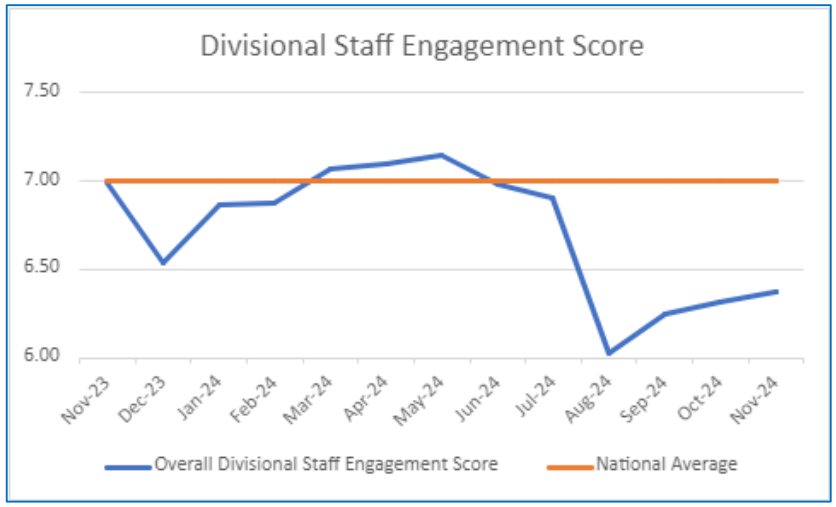
Medical - SAS Doctor	2.38	2.00	0.38
Medical - Resident Doctors	13.00	20.67	(7.67)

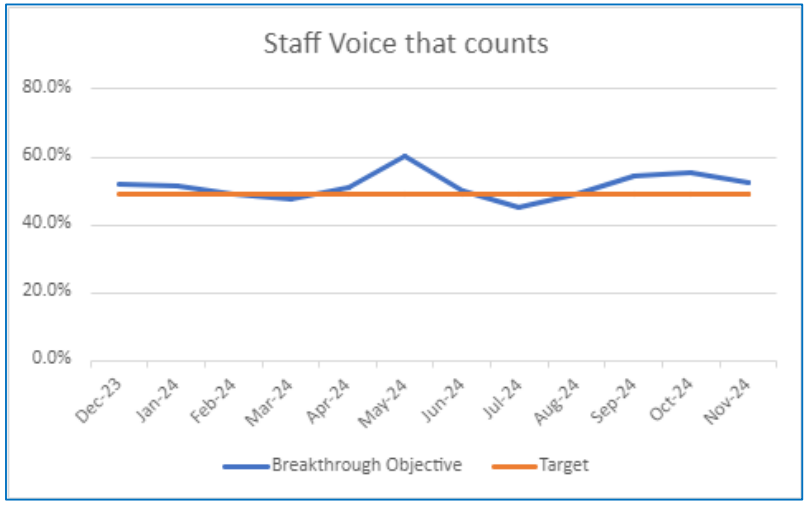
Medical rota support by ANNPs

ANNPs	Budget WTE	Contracted WTE	Vacancies
Nursing & Midwifery - Registered	11.81	15.85	(4.04)

Staff Engagement:

The Staff Voice that Counts Score for the Division has dropped below the Trust target. A reduction was expected because of the conversations regarding potential reconfiguration of services in response to workforce issues in Worthing. Staff engagement work continues, including Listening Events across the services, video messaging and service specific and Division wide newsletters. The lean and temporary leadership structure within operational, medical and nursing/ midwifery teams, impacts on the ability of leadership teams to maintain visibility and accessibility across diverse services and multiple sites. Now the Clinical Operating Model has been approved, recruitment into roles is progressing. Improvement in these measures is expected once embedded.





ImproveWell

The ImproveWell app is a tool to improve staff engagement and wellbeing. 187 members of the team (up from 181 last month) are now using the app, with 62 ideas having been submitted to date (up from 57 last month).

Good day and bad day word clouds

The good day measure function demonstrates that teamwork and colleagues are what makes a good day, and poor staffing impacts most on those experiencing their day as bad. Fill rates are now improving, which should begin to impact on engagement scores and staff satisfaction.

Conclusion and Recommendations:

Progress is being made with reducing vacancy rates, and this is now playing through into fill rates, and should allow our clinical teams to feel less pressured and more supported. The continued reduction in perinatal mortality and sustained below national benchmark brain injury rates, demonstrate the safety and quality improvement work impacts. Further work is needed on improving each way communication between clinical and leadership teams. The quadrumvirate have introduced 'Town Hall' style face to face sessions with the divisional teams to assist with open and transparent communication. We now also have a team of clinical Maternity Safety Champions, who will directly communicate with the leadership, executive and non-executive Safety Champions and share information with the clinical teams.

Report prepared by: Sally Harborow, Maternity Clinical Effectiveness Manager, Raili Frost, Maternity Improvement Programme Manager, Beckie Elms, Interim Head of Midwifery for RSCH & PRH, Gail Addison, Head of Midwifery for SRH & WH, Claire Hunt, Divisional Director of Nursing, Emma Chambers: Director of Midwifery

Date: 22nd January 2025

NHS
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University Hospitals Sussex NHS Foundation Trust ATAIN Quarterly Report Quarter: 2 Date: Jul 2024 - Sept 2024

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The ATAIN Programme: Background

In 2017, NHS England identified that over 20% of admissions of full-term babies into neonatal units could have been avoided. By providing services and staffing models that keep birthing people and their babies together, we can reduce the harm caused by separation.

Maternity and neonatal services need to work together to identify babies whose separation could be avoided, and to promote understanding of the importance of keeping birthing people and their babies together when it is clinically safe to do so.

Why is this so important?

There is overwhelming evidence that separation of birthing people and their babies so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on mental health, breastfeeding/chest feeding and long-term morbidity for the birthing person and child.

This makes preventing separation, except for compelling medical reasons, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

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The ATAIN Programme

The ATAIN programme was widely introduced in 2018 and forms part of what is now known as the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). The focus is on babies who are admitted for four key reasons, as these are areas that NHS England believe can have the most impact:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxic-ischaemia)

Data is collected and reviewed on a weekly basis by a multidisciplinary team which includes:

- Midwifery staff
- Obstetric staff
- Neonatal/Paediatric staff
- Neonatal Nursing staff

Often there is useful incidental learning identified when cases are reviewed, but the focus of the programme is to:

- Identify quality improvement work that could reduce causes of harm that can lead to term babies needing to be admitted to a neonatal unit
- Provide evidence to support the development of services that keep birthing people and their babies together when it is safe to do so

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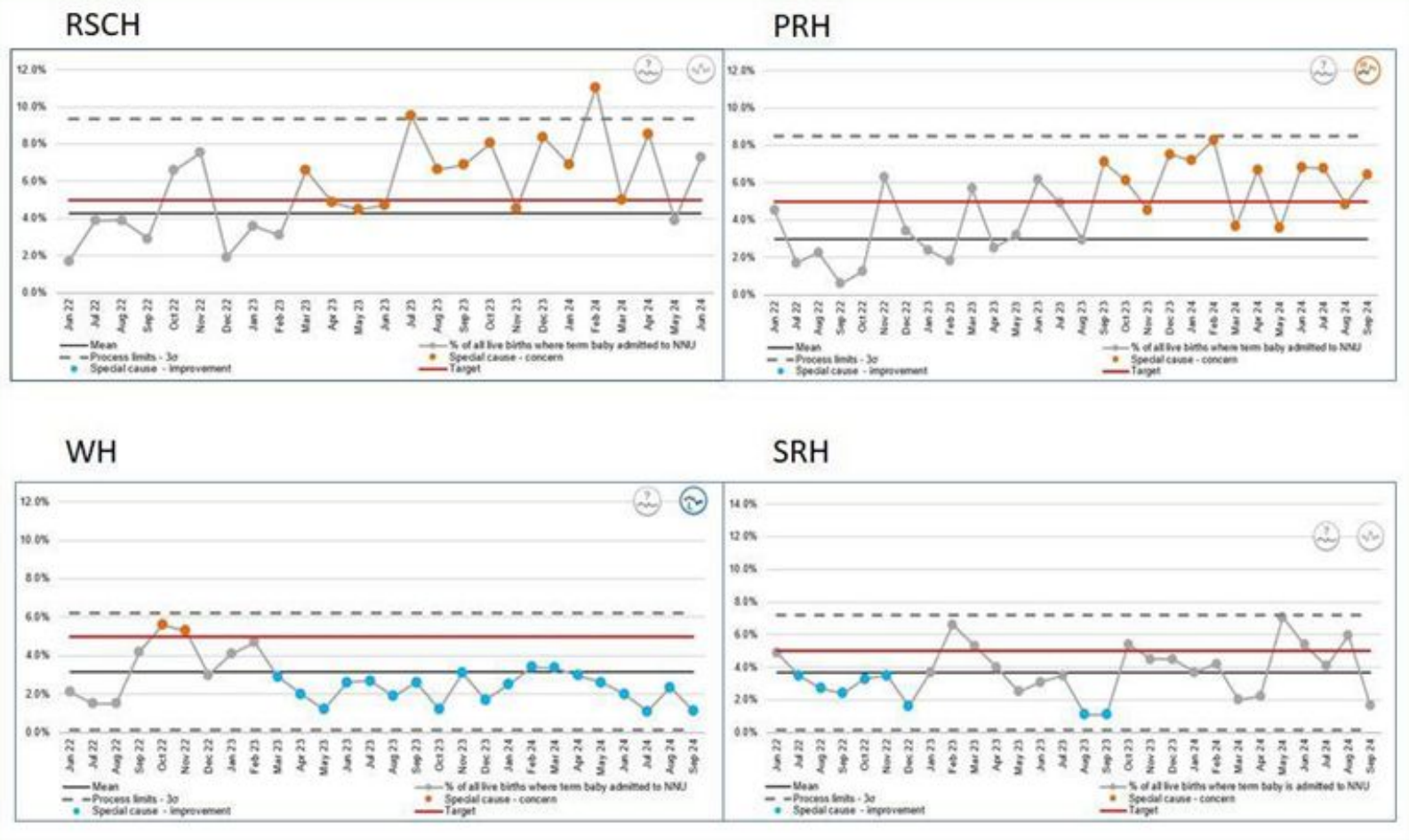
Term Admission Data – UH Sussex Summary

Term Admission Rate (Target <5%)



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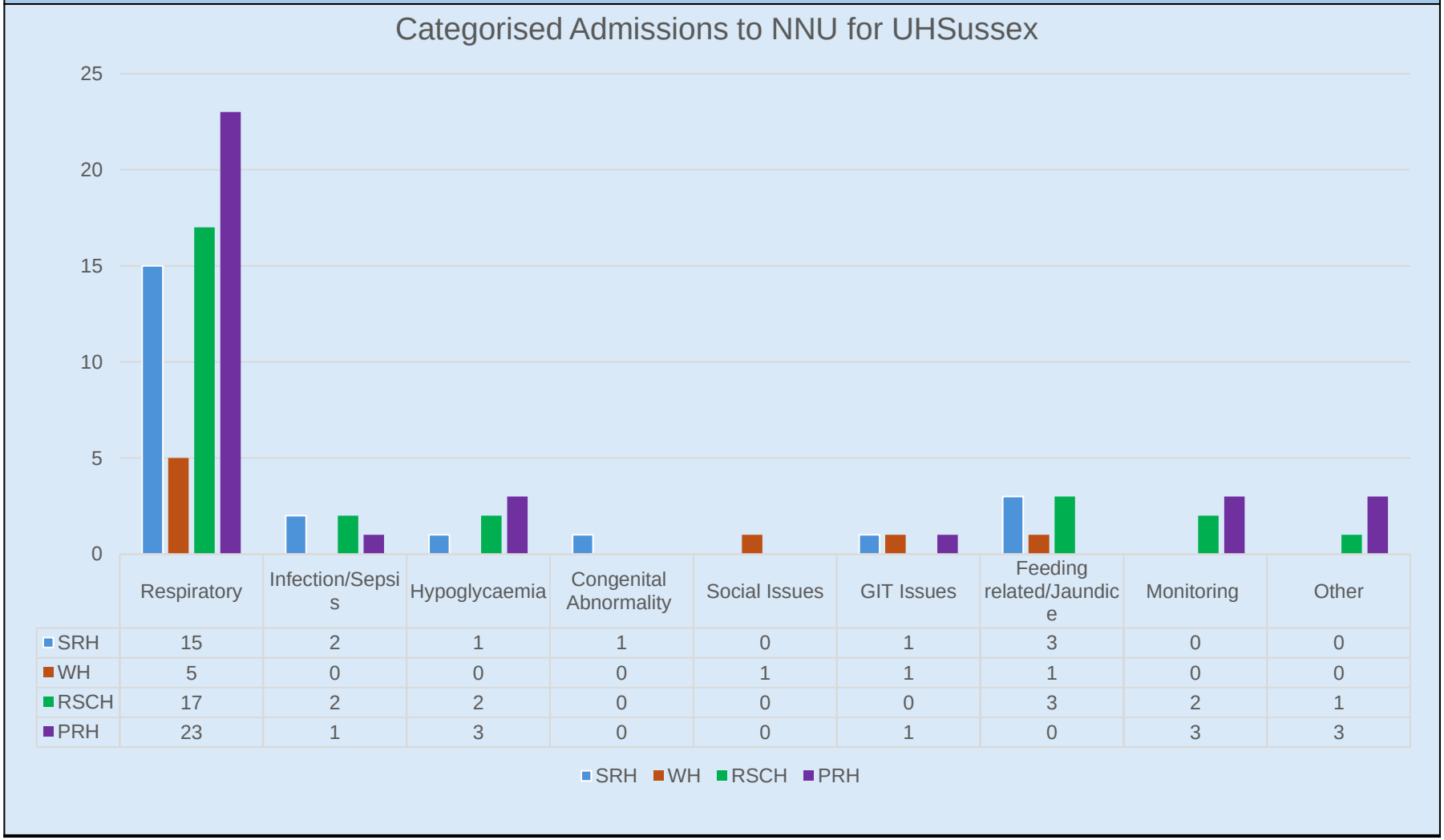
Categorised Admissions to NNU for UHSx



	Respiratory	Infection/Sepsis	Hypoglycaemia	Congenital Abnormality	Social Issues	GIT Issues	Feeding related/Jaundice	Monitoring	Other
SRH	15	2	1	1	0	1	3	0	0
WH	5	0	0	0	1	1	1	0	0
RSCH	17	2	2	0	0	0	3	2	1
PRH	23	1	3	0	0	1	0	3	3

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Royal Sussex County Hospital (RSCH)
ATAIN Progress Report

University Hospitals Sussex
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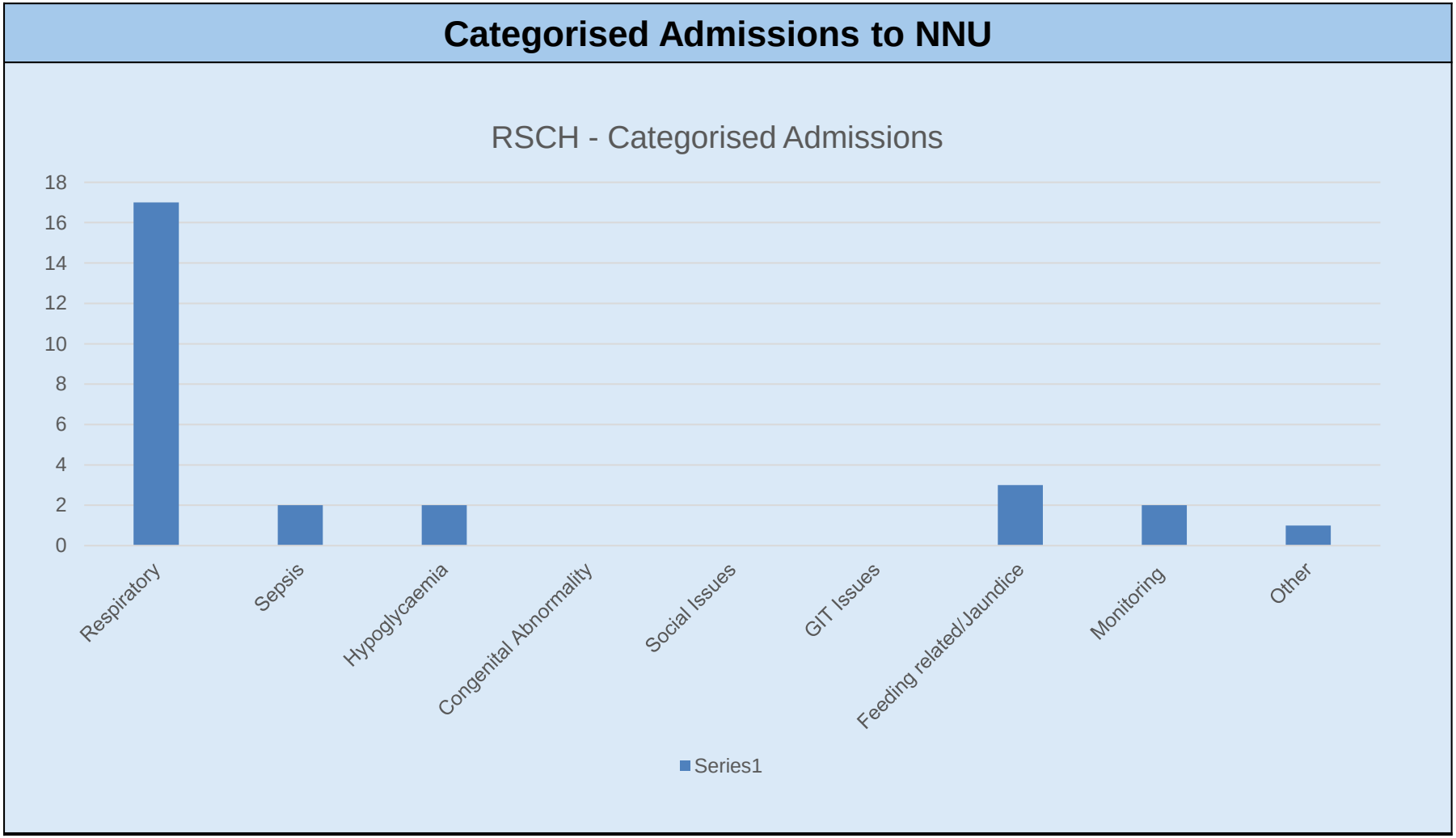
Categorised Admissions to NNU



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RSCH – Learning from the review of term admissions to NNU

Respiratory Symptoms

Number of admissions = 17
What type of respiratory symptoms:
- Low sats
- RDS
- Dusky episodes

Type of delivery they were: 7 SVD, 6 EMCS, 2 ELCS, 1 NBFD, 1 KIWI

Learning extracted

All admissions to the NNU for respiratory reasons were deemed as appropriate.

Infants being transferred from delivery suite following birth were given adequate time on the resuscitaire to adjust to extra-uterine life and were trialled appropriately at weaning the oxygen requirements before it was deemed unsafe to continue and admission was required for further respiratory support with Optiflow or ventilation.

1 infants was excluded within these numbers due to:
- Escalation of incident to MNSI

RSCH – Learning from the review of term admissions to NNU

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Hypoglycaemia

Number of admissions = **2**
Maternal risk factors increasing the risk of hypoglycaemia in the newborn:
•Mother had PET requiring antihypertensives
•Mother having PNMH involvement requiring SSRI medications and known cannabis user
Type of delivery they were: EMCS and SVD

Learning extracted

Of the 2 infants audited, 1 was deemed appropriate and the other avoidable.

The avoidable admission found that the newborn was unable to be admitted to the NNU following 3 x low blood glucose readings that had been treated appropriately with Glucoboost , however due to emergency admission, the newborn was not able to be transferred and subsequently dropped blood sugar again leading to admission to the unit. This was deemed avoidable as having a BAPM TC facility could have prevented this admission due to the infant receiving more tailored, one-to-one care within a TC setting and early implementation of the reluctant feeder protocol.

RSCH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Asphyxia (perinatal hypoxic-ischaemia)
1 Admissions for asphyxia that met cooling criteria (cooled for 72 hours)
Learning extracted
Precipitate delivery in standing position – maternal request Cord snapped at delivery and baby required resuscitation by consultant neonatologist and registrar. Recovered well and no further concerns. On reviewing notes, staff took appropriate action at the time.

RSCH – Learning from the review of term admissions to NNU

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Other
Number of admissions = 8 Type of delivery they were: 3 SVD, 2 NBFD, 1 ELCS, 2 EMCS Reasons for admission: • 3 x jaundice/feeding related • 2 x monitoring • 2 x sepsis/infections • 1 x other (no suck reflex and jaw misalignment)
Learning extracted
Of the 8 admissions, 5 were deemed appropriate and 3 avoidable. Monitoring admissions were for renal function bloods (creatinine 43) with support with feeding and for cardiac monitoring and repeat U&Es. With implementation of a BAPM T facility, these treatments could have been performed and thus avoiding admissions to the NNU and separation of mother and baby. One admission labelled ‘other’ was admitted for NGT due to jaw misalignment and lack of suck reflex. Again, with an implemented BAPM TC facility, this admission could have been avoided.

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RSCH Avoidable Admissions

RSCH Avoidable Admissions
Total number of avoidable admissions: 4 Themes: • Monitoring facilities on the PN ward • NGT siting on the PN ward • Staffing levels on the NNU to support admission as well as BAPM TC facility implementation to support the NNU

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Princess Royal Hospital (PRH)
ATAIN Progress Report

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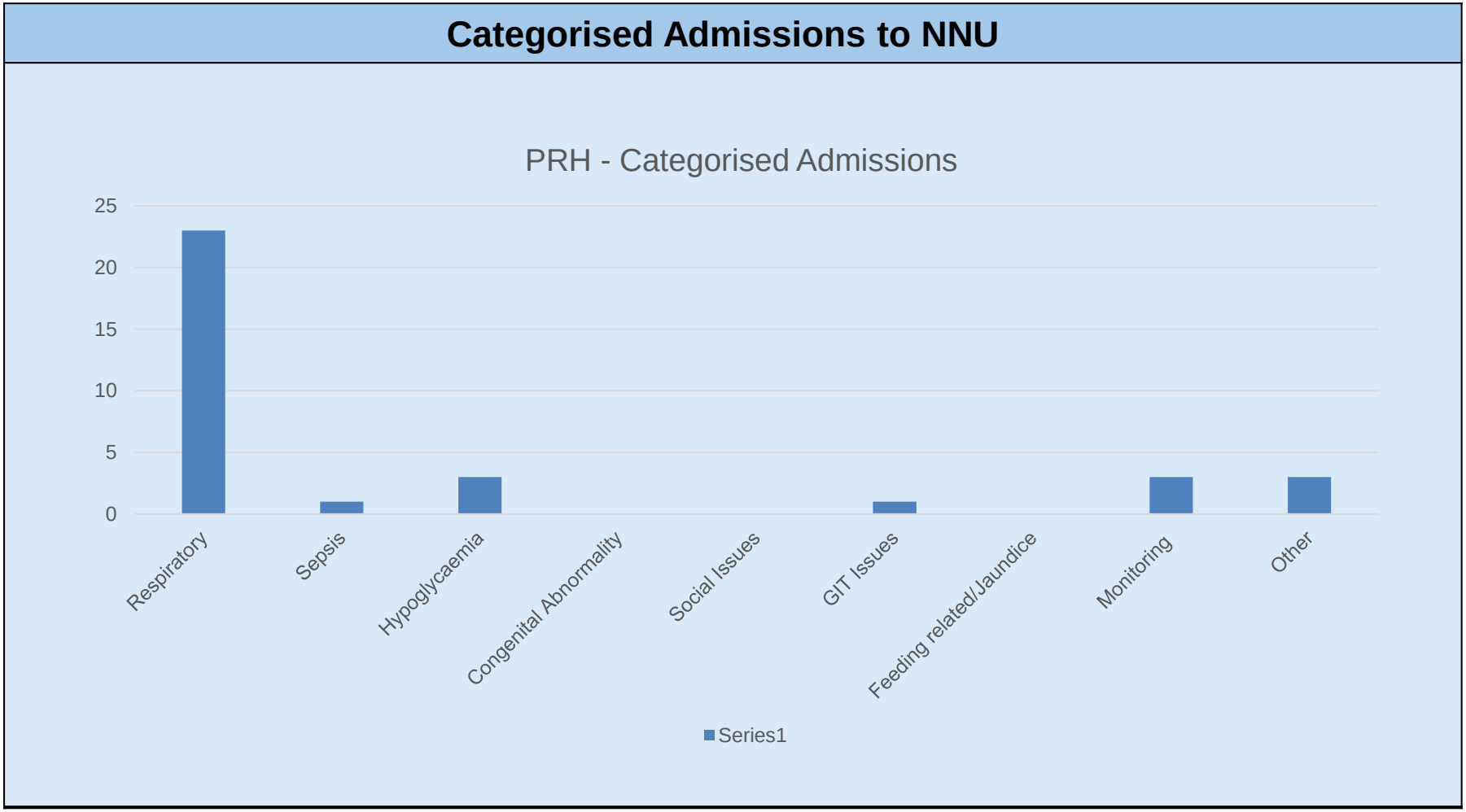
Categorised Admissions to NNU



PRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Respiratory Symptoms

Number of admissions: **23** – of these, all were deemed appropriate

What type of respiratory symptoms:
- RDS
- Pneumonia
- Suboptimal sats
- Dusky episodes

Type of delivery they were: 10 SVD, 2 NBFD, 5 ELCS, 6 EMCS

Learning extracted

All babies transferred to the NNU from delivery suite were given appropriate time to adjust to extrauterine life (>30mins) with additional respiratory support by means of facial O2, prone positioning and adequate thermoregulation on the resuscitaire.

22 infants commenced on Optiflow on admission to the NNU, with 1 infant requiring nasal cannula oxygen therapy.

1 infant required ventilation and surfactant.

PRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Hypoglycaemia
Number of admissions = 3 Type of delivery they were: 1 SVD, 2 EMCS
Learning extracted
All infants admitted to the NNU required IV glucose and one infant required an NGT alongside IV fluid therapy.

PRH – Learning from the review of term admissions to NNU

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Asphyxia (perinatal hypoxic-ischaemia)
0 Admissions for asphyxia
Learning extracted
N/A

PRH – Learning from the review of term admissions to NNU

University Hospitals Sussex
NHS Foundation Trust

Other
Number of admissions = 8 Type of delivery they were: 6 SVD, 1 ELCS, 1 EMCS
Learning extracted
Of the admissions the following themes can be drawn: • 1 x admission for raised lactate of 17 requiring bicarb correction. Symptomatic cardiac history and requirement for IV glucose • 1 x admission for poor infant feeding with antenatal diagnosis of bicuspid aortic valve, dilated ascending aorta and aberrant right subclavian artery – received care from the Evelina in utero. • 2 x admissions for convulsions • 1 x blood transfusion (Hb 118) following cord snapping at delivery • 1 x admissions for ECG monitoring for arrhythmia • 1 x surgical review transfer for bile-stained vomiting • 1 x cardiac monitoring admissions for bradycardia with prolonged QT interval

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PRH Avoidable Admissions

PRH Avoidable Admissions
N/A - all admissions reviewed were deemed appropriate

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Worthing Hospital
(WH)
ATAIN Progress Report

University Hospitals Sussex
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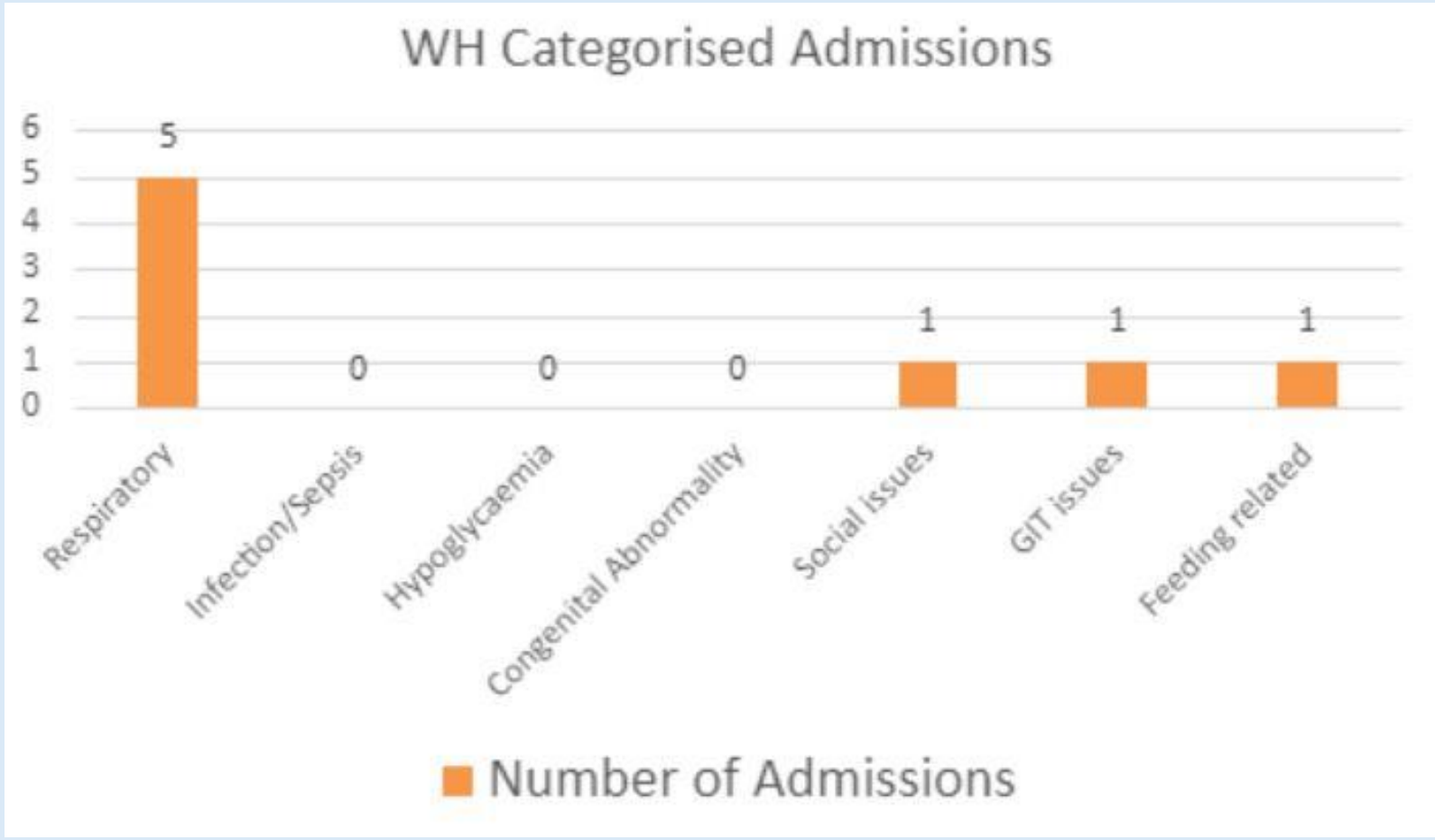
Categorised Admissions to NNU



WH – Learning from the review of term admissions to NNU

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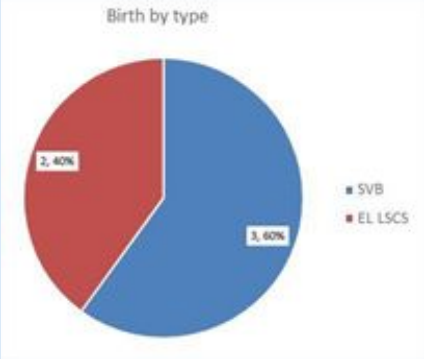
Respiratory Symptoms

Number of admissions = **5**

What type of respiratory symptoms:
- Low saturations with inability to maintain saturations without additional oxygen
- Chest recession
- Grunting/nasal flaring
- Diagnoses' include RDS, congenital pneumonia

Type of delivery they were: 3 SVB's & 2 ELCS



Learning extracted

All admissions to the NNU for respiratory reasons were deemed as **unavoidable**.

1 out of the 5 babies admitted received a fully 30 minutes of positive end-expiratory pressure (PEEP) with one baby only receiving 10 minutes before transferring to NNU. It is unclear from the notes if the other 3 babies had PEEP prior to optiflow.

All 5 babies received optiflow with an oxygen requirement to maintain oxygen saturations. 1 baby only required optiflow for 3 hours however remained on NNU for continued observation as the birth had been complicated by shoulder dystocia.

1 Elective caesarean birth was performed under general anaesthetic as the spinal had failed.

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WH – Learning from the review of term admissions to NNU

Hypoglycaemia / Jaundice / Asphyxia (perinatal hypoxic ischaemia)
There were 0 admissions to NNU for hypoglycaemia, jaundice or asphyxia (perinatal hypoxic ischaemia)
Learning extracted
N/A

WH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Other
Number of admissions = **3** Type of delivery they were: 2 SVB, 1 EL CS Reasons for admission: • 1 baby was initially taken to NNU for monitoring as there was concern around the baby being cyanosed following feeds. The baby was having neonatal abstinence scoring due to maternal substance misuse during pregnancy. A court order was granted and the baby was formally admitted as a place of safety. • 1 baby was admitted with bilious vomiting and following a period of monitoring required transfer for a upper gastro intestinal contrast/surgical review as is standard practice to rule out infection. • 1 baby was admitted for feeding support following projectile vomiting on day 2. The baby had been following a reluctant feeder pathway and had a comprehensive feeding plan by the specialist feeding advisor.
Learning extracted
All 3 babies were admitted from the postnatal ward. 1 of these babies was deemed an avoidable admission as the baby remained clinically well and could have been monitored on the PN ward.

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WH Avoidable Admissions

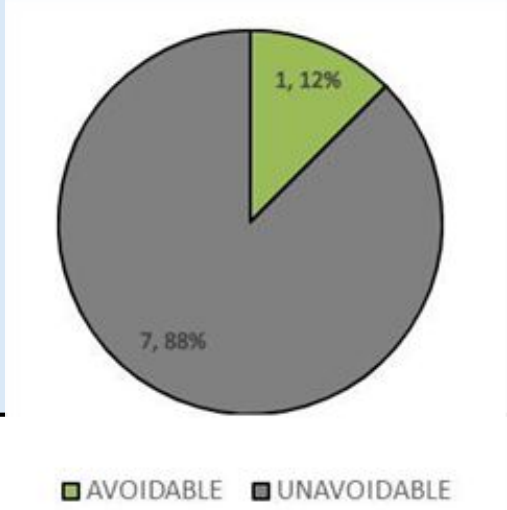
WH Avoidable Admissions

Total number of avoidable admissions: **1 out of 8** admissions were deemed **avoidable**;

This was the baby on the reluctant feeder pathway. Following the review it was concluded that the vomiting had been due to being overfed. The baby remained clinically well and did not receive any additional specialist input / tests or treatment whilst on NNU. Therefore it was considered this baby could have been monitored on the postnatal ward.

Themes identified throughout review:

- There does not seem to be consistency with the use of PEEP, however it is acknowledge that this is a very small sample (5).
This may be an area to explore with subsequent reviews.



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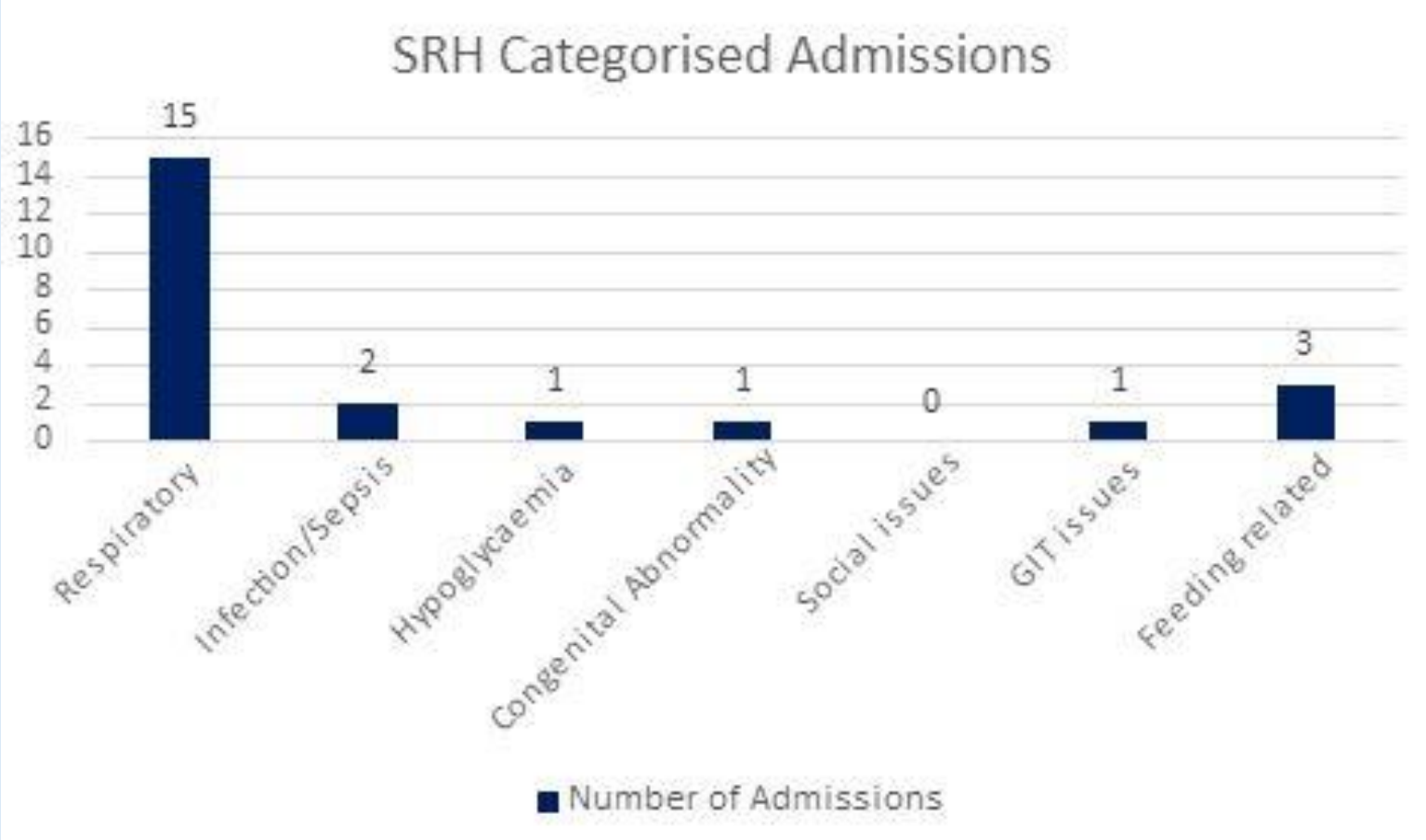
St Richards Hospital (SRH)
ATAIN Progress Report

NHS
University Hospitals Sussex
NHS Foundation Trust

Categorised Admissions to NNU



SRH – Learning from the review of term admissions to NNU

University Hospitals Sussex
NHS Foundation Trust

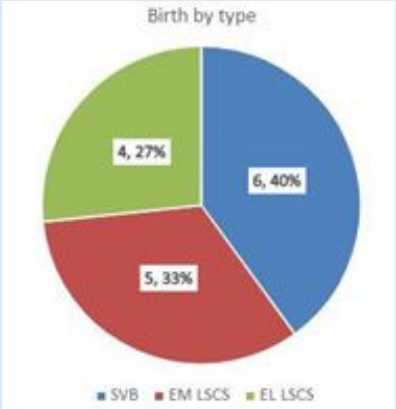
Respiratory Symptoms

Number of admissions = **15**

What type of respiratory symptoms:

- Low saturations with inability to maintain saturations without additional oxygen
- Chest recession
- Grunting/nasal flaring
- Increased work of breathing
- Dusky episodes
- Diagnoses' include Respiratory Distress Syndrome, Persistent Pulmonary Hypertension of the New-born, meconium aspiration and congenital pneumonia.

Types of delivery: 6 SVB, 5 EM CS (2 booked but laboured), 4 EL CS



Learning extracted

All admissions to the NNU for respiratory reasons were deemed as **unavoidable**.

Of the 13 babies transferred directly from the labour ward, all had had supportive positive end-expiratory pressure (PEEP) for at least 30 minutes to help facilitate the clearance of fluid from the lungs; therefore improving oxygenation by increasing lung volume and reducing alveolar collapse.

All babies required additional oxygen in order to maintain saturations above 90% necessitating admission to NNU for respiratory support with optiflow. It was noted that 2 of these babies had a low temperature on admission (<36.3).

2 babies required transfer to a tertiary centre, 1 with a diagnosed pneumothorax and 1 following full resuscitation requiring intubation following a category 1 LSCS with an abnormal antenatal CTG trace.

SRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Hypoglycaemia
Number of admissions = **1** Type of delivery they were - SVB
Learning extracted
This baby was born at 39 weeks gestation and was admitted to NNU on day 1 from the postnatal ward. This admission was deemed potentially avoidable as although the baby was treated with a glucose bolus there was no clear indication from the notes why a nasal gastric tube (NGT) had been inserted as no NG feeds were required. It was considered this baby could have been cared for in the transitional care setting.

Jaundice & Asphyxia (perinatal hypoxic-ischaemia)
0 Admissions to NNU for jaundice or asphyxia
Learning extracted
N/A

SRH – Learning from the review of term admissions to NNU

University Hospitals Sussex NHS Foundation Trust

Other
Number of admissions = **7** Type of delivery they were: 3 SVB, 2 NBFD, 2 EM CS Reasons for admission: • 1 baby was admitted with bilious vomiting and following a period of monitoring required transfer for a upper gastro intestinal contrast/surgical review. • 3 babies required feeding support and had nasal gastric tubes (NGT) inserted. 1 of these babies required a frenulotomy. 1 was associated with a feeding intolerance having increased vomiting with associated desaturations needing a higher level of care. • 2 babies were admitted with signs of infection (tachycardia, raised temperature) requiring enhanced monitoring and further treatment/investigations. 1 babies also had abnormal neonatal abstinence scoring (NAS). • 1 baby was born with a rare genetic condition (epidermolysis bullosa) parent's unknown carriers. Sadly, this baby died at 15 days of age.
Learning extracted
• 1 baby admitted ‘sleepy’ with poor feeding had a low temperature on arrival to NNU. This admission was considered avoidable as not only the baby was cold a feed was not encouraged prior to inserting an NG tube. • 2 of these babies had received additional support at the time of birth in the form of PEEP, 1 having had a period of monitoring in NNU but returned to the mother within 4 hours. • 6 of the 7 babies were admitted from the postnatal ward (excluding the baby with the diagnosed genetic condition).

SRH Avoidable Admissions

University Hospitals Sussex NHS Foundation Trust

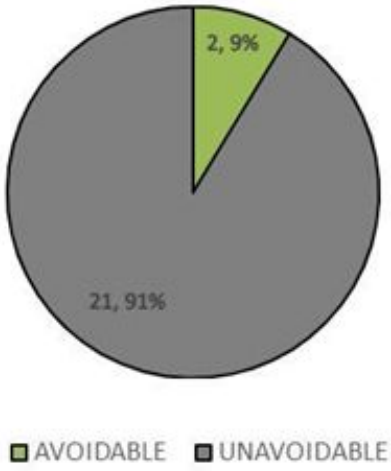
SRH Avoidable Admissions

Total number of avoidable admissions: **2 out of 23** admissions were deemed **avoidable**;

- However there is emphasis that if there was an enhanced transitional care setting with an increased skillset the babies requiring NGT insertion for example could potentially remain with their birthing mother/person.

Themes identified throughout review:

- Temperature regulation - 3 babies were cold on admission to NNU – 2 from LW, 1 from PN ward
- Enhanced monitoring facilities on the PN ward
- NGT siting on the PN ward
- Increased confidence from staff (both NNU staff and TC staff) to allow babies to remain within transitional care facility



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Acknowledgement

With the review of these cases, it must be acknowledged that each review is completed in isolation with known limitations. The acuity at the time of each birth is not reviewed, therefore it is not known what other clinical activity there is across all departments, what the staffing level is and if there are any other factors that may influence a decision to admit a baby to NNU. An addition to this review to help inform the QI work into ATAIN would be to do a deeper dive into the time each baby spends on NNU to determine if there is any opportunity to return babies back to their mothers/ birthing person sooner under transitional care and if there is anything that hinders this process.

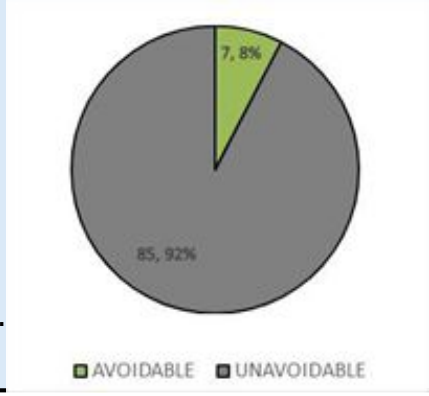
Summary

For the total of Quarter 2, the benchmark of <5% of admission to the Special Care Baby Unit was met for the duration at WH (1.0%, 2.3% & 1.1%). SRH met the benchmark in July & September (4.0%, 5.9% & 1.6%). PRH and RSCH met the benchmark in August only (PRH - 6.8%, 4.85%, 6.42%, RSCH 6.0&, 4.7%, 6.0%).

There were 27 admissions to NNU from RSCH, 34 admissions from PRH, 23 admissions from SRH and 18 admissions to from WH which is a total of 92 term admissions to the SCBU/NNU.

The majority reason for admission this quarter across all four sites was again due to respiratory support.

Overall, 92.4% (85) of admissions across all four sites were considered unavoidable with appropriate management with 7.6% (7 cases) considered as potentially avoidable. This is a reduction of 1.9% (from 9.5%) when compared to Q1.



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Summary of progress

ATAIN Action Tracker Review - 2023 and 2024

RAG Status Key: Red: Outstanding Action Amber: In Progress Green: Completed

Date Opened	Site/ Location	ATAIN or TC	Summary of Issues Identified/ Background of Concern	Action	Lead	Comments	Date Due	RAG Status
15/09/2023	All	Both	Sharing of lessons learned from audit.	To share audit outcomes via the Safety Boards within clinical areas.	Gov Leads	Following sharing of reports via Q&S meeting, to share lessons to Safety Boards. **08/08/2024** Sally to discuss with the Governance leads. **Sept 24:** to be raised in next Gov leads meeting Sept.	01/10/2024	
15/09/2023	All	TC	For the maternity and neonatal team to map out the feasibility of siting cannula's and giving antibiotics in the birthing room, to keep mother/birthing parent and baby together.	To share findings and discuss at LMNS meeting with neonatal representation across all sites for agreement of plan.	LMNS	**ON HOLD.** Agree plan moving forward when shared at next LMNS meeting (12/10/2023). Attempted discussion at LMNS but not afforded time- to consider bringing back to LMNS when joint with neonatal for wider discussion. **08/08/24** - ongoing. Very opposing views and links to whether admission is recorded.	On hold until other aspects are completed.	
15/09/2023	All	TC	Consider a review of babies admitted to SCBU for short periods of observation to determine if additional support from SCBU may enable these babies to remain with their parents on the PN ward.	Working party to review and address any training needs or support required for this provision.	All	Working party established at RSCH and PRH. To meet at WH and SRH to replicate with neonatal leads. Good progress made and led by NH. **08/08/24** - ongoing and will form part of this group.	01/10/2024	
15/09/2023	All	TC	Establish clear criteria for which babies require IV antibiotics, with particular regard for babies whose mothers are commenced on IV antibiotics in the postnatal period.	Consideration should be given to introduction of the Neonatal Early-Onset Sepsis Calculator to standardise which babies are given IV antibiotics after birth.	Neonatal Leads	SRH currently piloting tool- to share results at meeting for possible introduction across WH site. RSCH and PRH already undertake tool and to commence audit. To consider joint meeting with all sites to establish what works well versus gaps. Update needed from neonatal leads. **08/08/24** hope to incorporate use of tool across sites, but ongoing. Guidance to be reviewed and refreshed. Linking with SB. **Sept 24:** Cons neonatologist Svilena Dimitrova is looking at the guidance around the Kaiser Permanente Calculator and Neonatal antibiotics. (4 sites).	01/10/2024	
15/09/2023	All	TC	To continue to discuss the best location of documenting neonatal medical reviews to ensure contemporaneous record keeping by paediatricians.	With the different information systems in use, TC babies are at risk of having their care documented on a system not accessible by one of the staff group. To discuss way forward at working party.	PN leads	Confirmation of shared learning at Neonatal and Child's Services Governance meeting. To consider raising on Risk Register with known risk of documenting care in more than one place. Badgernet lead now working on audits to support this action. **08/08/24** now there is an agreement that any care on PN ward must be recorded on Badgernotes. Improving but still some gaps. (PN leads). Need list of new doctors to share cribsheet. **Sept 24:** links to row 16 SBAR action.	01/10/2024	
15/09/2023	RSCH/ PRH	ATTAIN	To review obstetric attendance at ATAIN review meetings to broaden the MDT scope.	For Clinical Director to identify responsible obstetrician to partake in reviews.	COS	Nationally required recommendation for review of ATTAIN cases by MDT. Obstetric PA allocation currently being reviewed by COS **08/08/24** - needs strengthening on RSCH/PRH. WH/SRH obstetric care reviewed in incident process thoroughly. When ATAIN review happens, present initial review to paeds cons, patient safety consultant (monthly). NH and EM to link with MC. EM to reach out to Essex Trusts for learning.	01/10/2024	
12/12/2023	All	Both	To review hypothermia guidance to ensure that environmenta and transfer temperature control has recommendations for clinical practice within.	Quality Lead	SH	**08/08/24** - Edward Yates reviewing guidance. SH to check. **Sept 24:** Update to come, with support from CE team coming.	01/10/2024	
08/08/2024	All	ATAIN	Hypoglycaemia admissions - review of last 6 months to inform QI project. These cases are small in number but complicated on Neonatal unit.	PN leads to develop QI project focussing on embedding basics well across 4 sites inc: keeping babies warm, well fed with good feeding support after birth, training. Consider appropriate escalations as shown in Q1 report.	NH, PN leads, LW leads (supported by matrons)	**Sept 24:** To include feeding leads. Group meeting to begin A3, RF to support PMO and set up and MZ to support.		
08/08/2024	PRH	TC	ANNP daily reviews not being recorded	HoM, neonatal matron and PN lead to review and discuss possible reasons. To share in next meeting	RE, ZH, EM	**Sept 24:** To check with EM. PRH ANNPs access to Badger has been a barrier, but with improved staffing, should improve.		
08/08/2024	RSCH/PRH/WH	Both	SBAR recording on Badgernet to be improved across other 3 sites.	Focus on neonatal SBAR and then broaden to LW SBARs.	PN, Neonatal leads, LW leads	**Sept 24:** SM looking into changes to accommodate on Badger, but likely to have delays. SBAR data collections to be audited to improve across matneo. Involve EPR leads.		

New actions will be added after dissemination of the report, agreed through the ATAIN & TC steering group

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Transitional Care

Quarter 2 (July, August, September 2024)

PRH, RSCH, SRH, WH

Contents

Background 2
Criteria for Neonatal Transitional Care 3
Objective 3
Standards ..... **Error! Bookmark not defined.**
Data collection 3
Results 4
Themes 9
Recommendations 9
Overall Conclusion ..... **Error! Bookmark not defined.**

Background

Neonatal Transitional Care (NTC) is defined as care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals.

Keeping mothers and babies together should be the cornerstone of newborn care. NTC supports resident mothers as primary care providers for their babies with care requirements more than normal newborn care, but who do not require care in NNU.

Implementation of NTC has the potential to prevent thousands of admissions annually to UK neonatal units, and to provide additional support for small and/or late preterm babies and their families. NTC also helps to ensure a smooth transition to discharge home from the neonatal unit for sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home.

NTC is multidisciplinary and should be flexible and responsive to mother and baby's physical and emotional needs as well as the rest of the family. A recent systematic review concluded that "transitional care benefits the health outcomes of moderately compromised infants and mothers in terms of de-medicalising care, improving mother and baby attachments, avoiding separation, developing parenting skills for dependent infants and raising the potential for shorter length of hospitalisation". *British Association of Perinatal Medicine (BAPM) Neonatal Transitional Care - A Framework for Practice (2017). A BAPM Framework for Practice.* Potential benefits of transitional care:

For mother and baby:

- Optimised attachment process.
- Maximal opportunities for skin-to-skin contact.
- Facilitation of baby-led feeding and establishment of breast feeding.
- Access to 24-hour practical support with feeding and /or prompt medical review if required– helping to build self-efficacy and thus confidence in parenting.
- Immediate access to skilled midwifery support for routine postnatal care.
- Family-friendly environment.
- Potentially reduced risk of hospital-acquired infection.

For maternity and neonatal services:

- Reduced length of neonatal stay.
- Improved team working within maternity and neonatal services.
- Greater parental confidence, with reduced rates of re-admission.
- Increased breast-feeding rates.
- Improved neonatal patient flow with potential for more efficient use of NNU cots.
- Additional professional opportunities for midwives.

Criteria for Neonatal Transitional Care

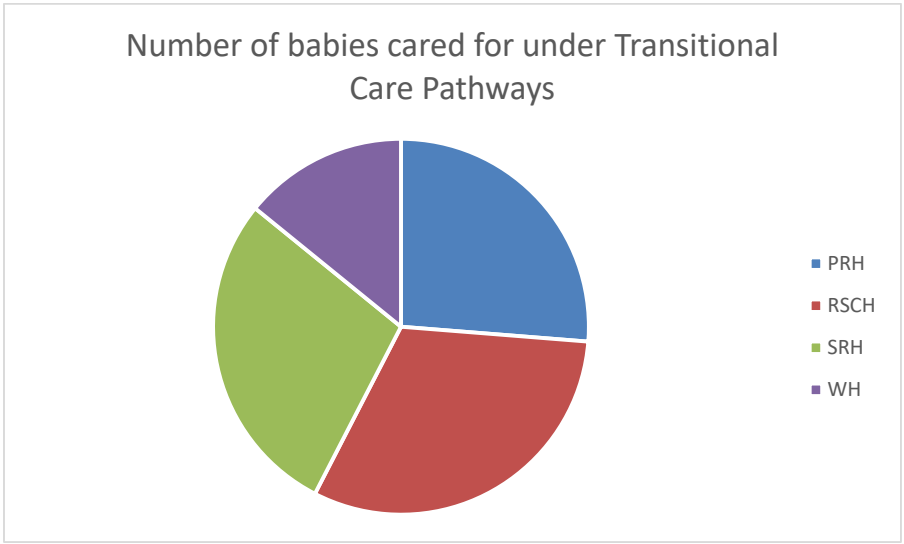
- Gestation 35-36+6 weeks at birth who do not fulfil criteria for intensive or high dependency care.
- Risk factors for sepsis requiring IV antibiotics, but clinically stable and/or stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
- At risk of haemolytic disease requiring immediate phototherapy or requiring phototherapy following identification on the ward or in community.
- Excessive weight loss.

Objective

To provide assurance that the neonatal pathway into Transitional Care is fully implemented within the neonatal and maternity teams.

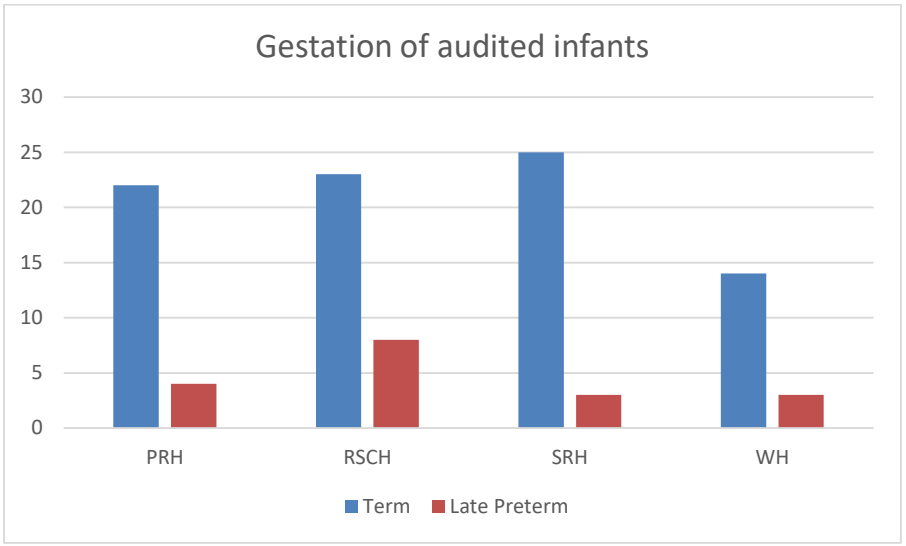
Data collection

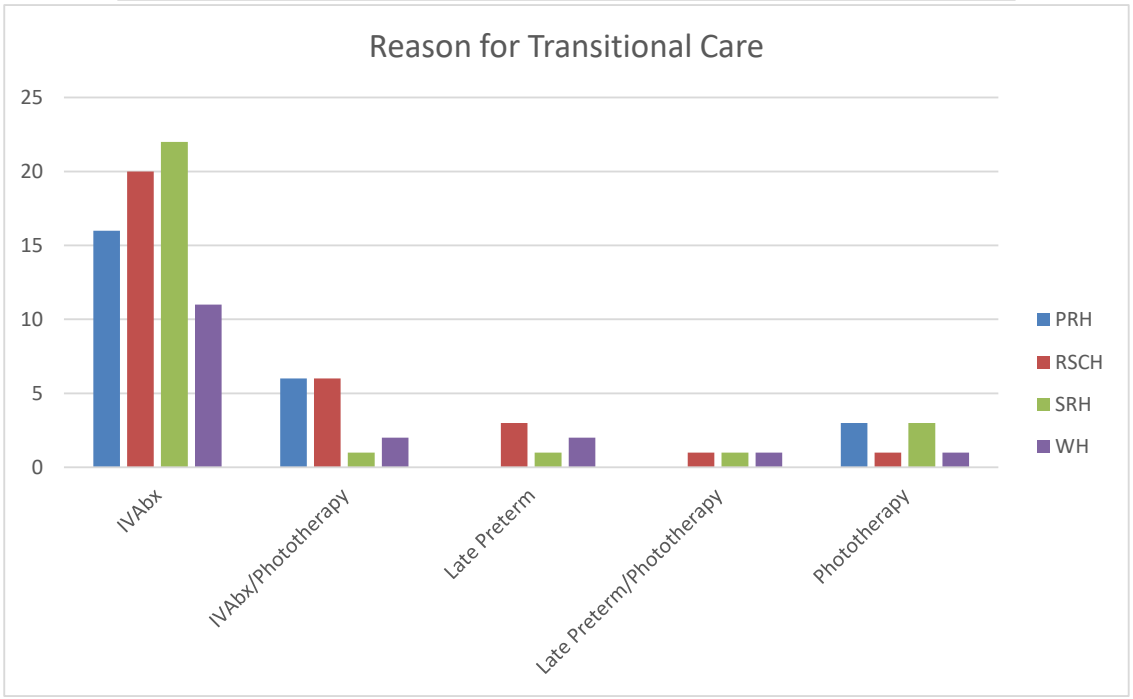
A sample of neonatal medical records of babies who met the criteria for Neonatal Transitional Care were audited between a 3-month period of July to September 2024. Infant's care pathways, via their neonatal medical records on Badgernet were audited: PRH 26 sets, RSCH 31 sets, SRH 28 sets and WH 17 sets.



Results

Most of the cases audited were term gestation neonates.

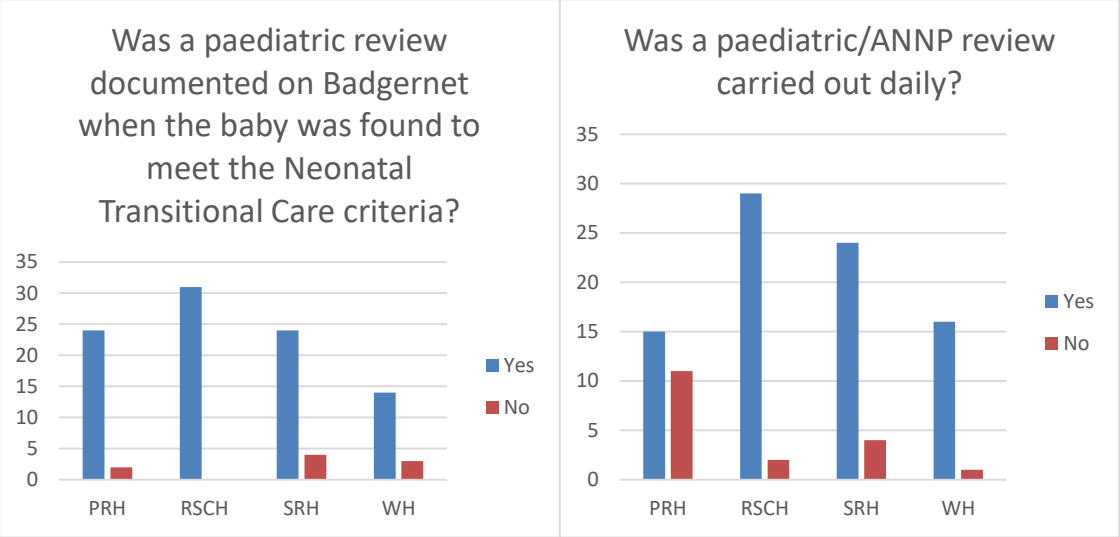




Most babies under Transitional Care, as shown in the graph above, were found in the category of receiving intravenous antibiotics for suspected sepsis. Some babies had multiple treatments during their admission.

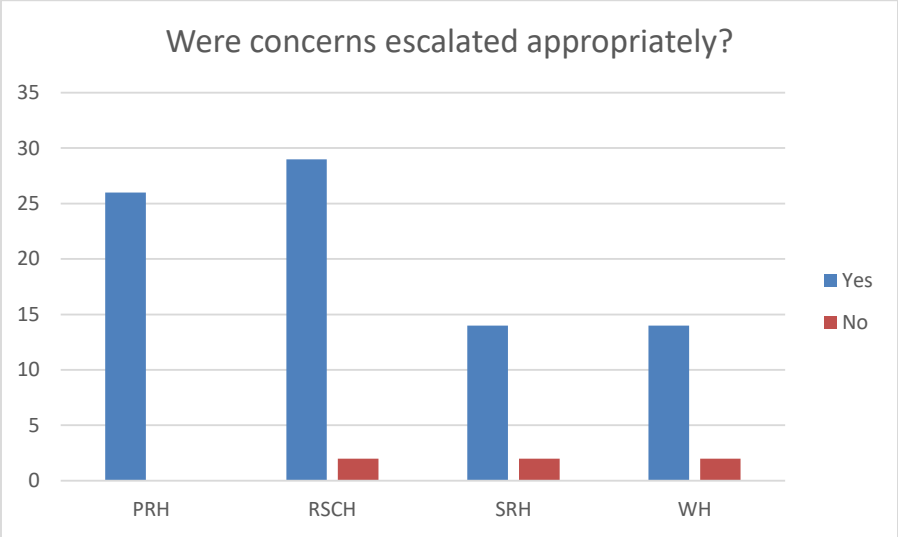
Record of Neonatal Medical Involvement

Neonatal teams should be involved in the decision making and planning of care for all babies in transitional care and should have a review each day they are under Transitional Care. Reviews should be documented within the Badgernet record.



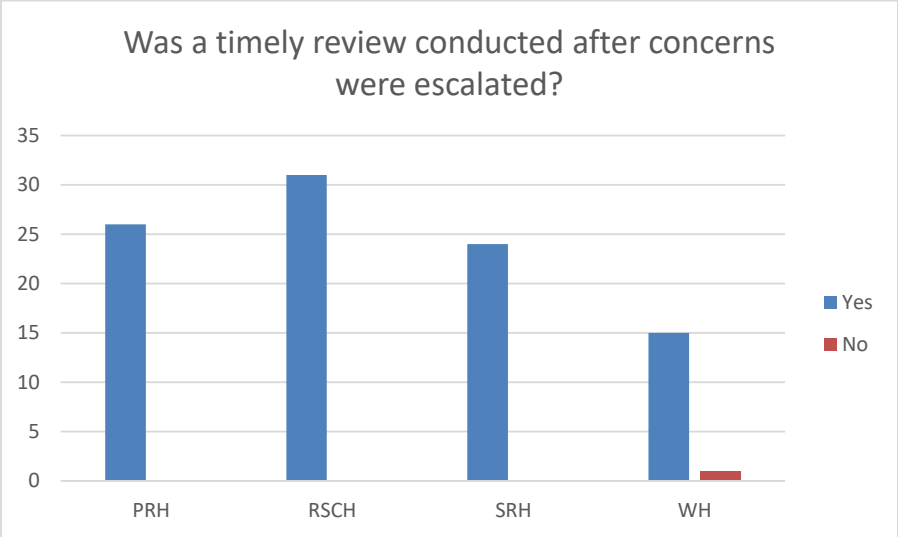
Most cases were appropriately reviewed when found to meet the Neonatal Transitional Care criteria. However, documentation of Neonatal/Paediatric reviews showed gaps in 9 cases (2 at PRH, all babies audited at RSCH had a daily neonatal review, 4 at SRH and 3 at WH) where initial review and decision to start TC was not documented. This could be attributed to the documentation being located separately on Metavision or paper notes. However, this cannot be confirmed as this was beyond the scope of this audit. When reviewing notes, the baby's transitional care pathway was clear. 1 baby at PRH was not seen by the paediatric team at all whilst on phototherapy

Daily reviews were documented in 84 out of 102 cases. These were most commonly not undertaken at PRH. We recognise that work continues to be required at PRH to ensure that all babies have a daily review whilst on transitional care pathways. This is likely to continue to be due to 1 ANNP who covers both labour ward and the postnatal ward workload, as well as SCBU. TC babies care is overseen by both nursery nurses and midwives, who do escalate any concerns with these babies, therefore babies on Transitional Care who are clinically well will be the lowest priority. Additional paediatric support at PRH is needed to meet this standard and this has been added to the risk register.

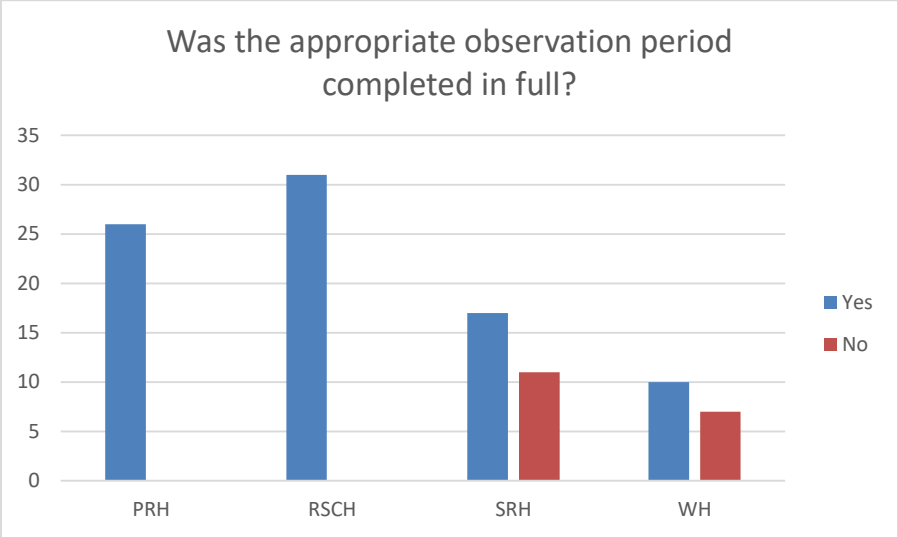


For the majority of neonates, any concerns were escalated appropriately. For those that were not:

- Action was not taken to following identification of low temperatures on labour ward at RSCH
- There were 2 cases of observations not escalated appropriately at Worthing. Individual feedback has been given to these staff members about this.



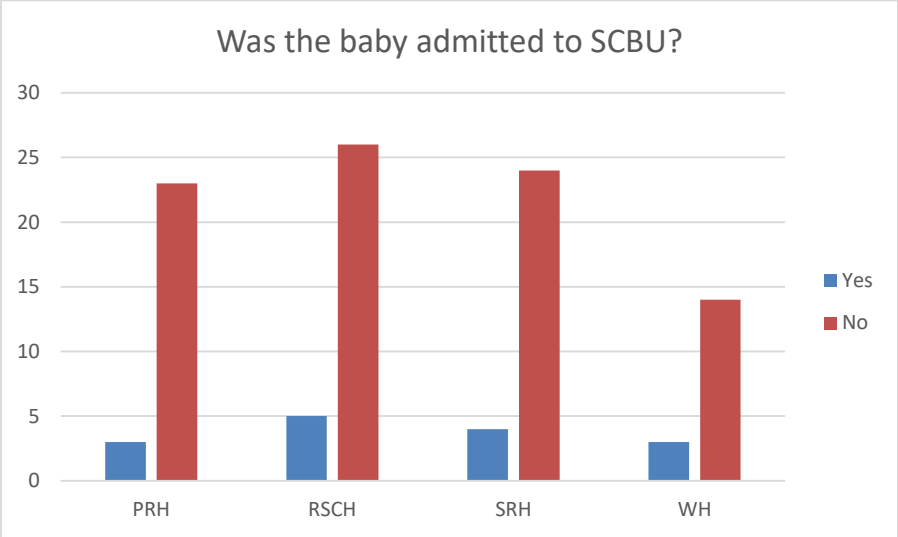
There was only 1 baby at WH that did not receive a timely review from the Paediatric team when this was escalated to them. The Paediatric team were bleeped 5 times before the baby was reviewed and then admitted to Beeding ward for Opti flow. This case has been reviewed by the MDT as part of the ATAIN process. However, the other 95 babies in this audit were seen in a timely manner.



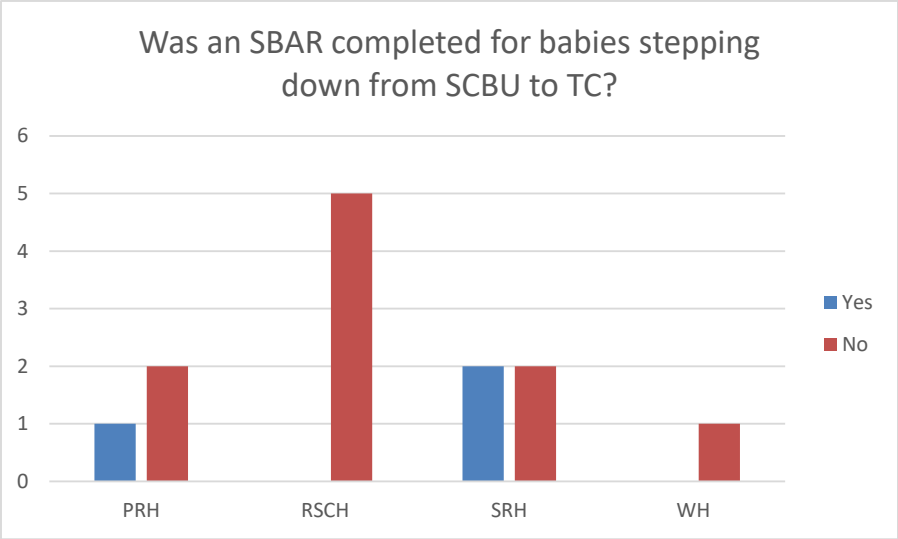
There is a significant difference between achieving the full observation period at WH and SRH compared to PRH and RSCH. It must be acknowledged that staffing of Nursery Nurses /ANNP is different at PRH/RSCH compared to WH/SRH. On review of the guidance, there is significant difference in what is required at each site, as seen in the table below. In order to be able to directly compare each ward for this standard, these guidelines should be reviewed and aligned.

	PRH/RSCH	SRH/WH
TC		
IV Abx	6 hourly full set observations 4 hourly random blood glucose for 24 hours >2.5mmol/L	4 hourly full set observations
Late preterm	No specific guideline, will be on hypoglycaemia pathway	3 prefeed blood glucose >2.5 30 min obs for 2 hours 4 hourly for 24 hours BD until discharge (after 72 hours)
Hypopathway	4 hourly prefeed blood glucose >2.5 mmol/L with temperature 12 hours if GDM (diet), antihypertensives, macrosomic, SSRIs 24 hours if medicated GDM	2 prefeed blood glucose ≥2.0. If both <2.5, one needs to be done on gas to confirm >2.0
Phototherapy	6 hourly temperature	4 hourly full set observations Daily weight
Non-TC		
Hypothermia	4 hourly temperature	4 hourly temperature
Sepsis obs	2 hourly for 12 hours GBS- 2 hourly for 24 hours, if had 2 doses antibiotics then normal sepsis obs	Guideline: 12 hours 2 hourly obs
NAS	4 hourly/when settled after feed	4 hourly
Meconium	Thin: 1 and 2 hours of age	Thin: 1 and 2 hours of age

	Thick: 1 and 2 hours of age, 2 hourly until 12 hours	Thick: 1 and 2 hours of age, 2 hourly until 12 hours
Kaiser	For babies at risk, should be on 4 hourly observation for 24 hours, however this is inconsistently applied and many babies are having much more frequent observations than this.	



TC admission to NNU is shown in the graph above. A proportion of all babies audited were admitted to the neonatal unit. 3 at PRH, 5 at RSCH, 4 at SRH and 3 at WH. Half of these cases were for respiratory support with other reasons primarily being sepsis and prematurity.



Audit of the use of SBAR handover tool within Badgernet is a new addition to this report. SBARs are generally being completed, however these are on paper and not contained within Badgernet. This will be one of the themes in the postnatal theme of the week.

Themes

This audit has identified areas for improvement. Maintaining good practice is essential and in cases where escalation is required this should be undertaken through a timely Neonatal/Paediatric review. Daily Neonatal/Paediatric review should be ensured for TC babies.

Across the audit several themes were identified:

- Treatment with IV antibiotics was the main course of treatment across site.
- Daily neonatal reviews need to be documented in Maternal BadgerNet under the Baby postnatal record; however, it was found the location of documentation varied. This continues from last quarter.
- Delay in neonatal team reviews being performed/documented on BadgerNet due to staffing constraints or increased workload pressures on the unit.
- Several babies are admitted to NNU for short periods of observation, before being transferred back to the postnatal ward.
- Poorer completion of neonatal observations at SRH and WH.
- Challenges continue to conduct daily ward round of TC babies at PRH.

Recommendations

The results of this audit are shared with the Maternity, Neonatal and Board Level Safety Champions, and used to inform QI work as part of the Transitional Care and ATAIN UHSx Steering group. Actions are tracked through the ATAIN and TC action tracker: ATAIN and TC action tracker

- Implementation of Postnatal Theme of the Month. This will be like the new Maternity theme of the week, but focus on issues on the Postnatal ward, and will be discussed at safety huddles each day throughout the month to ensure all staff are aware. The first two themes will be around escalating concerns and the use of SBAR handovers for babies transferring between wards. This still needs to be implemented and is the focus of the new year.
- QI project across all four sites focussing on neonatal care with a focus on hypoglycaemia, feeding and SBAR
- Review and align neonatal guidance across all four hospital sites.
- Review and increase paediatric staffing capacity at PRH.
- In person paediatric review required when baby identified as requiring phototherapy.

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Mortality and Learning from Deaths 2024/25 Q3 Report

Caroline Wiggs - Mortality & Learning from Deaths Manager

January 2025

Learning from Death Mortality Overview - 2024/25 Q3

*Data source SHMI Module HEDS and includes of out of hospital deaths. Latest data available.

NHS University Hospitals Sussex NHS Foundation Trust

		Total Adult Deaths	Total Inpatient Deaths	Total A&E/ED Deaths	Total Adult Deaths within 30 days of discharge*	Crude Mortality*	HSMR (12 Month Rolling)*	SHMI (12 Month Rolling)*
Oct-24	WGH	99	93	6		3.12		
	SRH	80	79	1		2.87		
	RSCH	112	101	11		2.63		
	PRH	27	23	4		1.40		
		318	**296**	**22**		**2.63**		
Nov-24	WGH	101	94	7		3.14		
	SRH	93	91	2		2.84		
	RSCH	118	109	9		2.62		
	PRH	22	21	1		1.35		
		334	**315**	**19**		**2.62**		
Dec-24	WGH	111	103	8				
	SRH	108	101	7				
	RSCH	135	120	15				
	PRH	55	49	6				
2024/25		**409**	**373**	**36**				
Q3	**UHSx**	**1061**	**984**	**77**				

October to December 2024

- **1061** adult deaths (decrease from **1173** in 2023/24 Q3; increase from **923** in 2024/25 Q2.)
- **984** inpatient deaths (decrease from **1073** in 2023/24 Q3; increase from **846** in 2024/25 Q2.)
- **77** ED deaths (decrease from **100** in 2023/24 Q3; **equal** to 2024/25 Q2.)
- Total **adult deaths within 30 days of discharge; HSMR** and **SHMI data** for Q3 awaited. Available 2024/25 Q2 data provided opposite.

		Total Adult Deaths within 30 days of discharge*	Crude Mortality*	HSMR (12 Month Rolling)*	SHMI (12 Month Rolling)*
Jul-24	WGH	45	3.02	107.71	102.81
	SRH	30	2.98	98.42	105.58
	RSCH	31	2.66	97.10	110.76
	PRH	15	1.49	72.07	92.67
		121	**2.66**	**95.98**	**104.27**
Aug-24	WGH	34	3.06	103.38	101.87
	SRH	24	2.93	99.01	104.23
	RSCH	25	2.68	97.58	111.98
	PRH	18	1.49	74.50	94.11
		101	**2.66**	**96.57**	**104.05**
Sep-24	WGH		3.10	103.63	
	SRH		2.85	98.51	
	RSCH		2.67	96.96	
	PRH		1.47	70.15	
2024/25			**2.65**	**95.79**	
Q2	**UHSx**	**222**			

The SHMI is the ratio between the actual number of patients who die following hospitalisation at UHSx and the number that would be expected to die on the basis of average England figures.

Learning from Death Mortality Demographics - 2024/25 Q3

Deaths by IMD Decile (1 = most deprived, 10 = least deprived)

Breakdown by month

Demographics for Adult Deaths					
	Oct-24	Nov-24	Dec-24	UHSx Q3 Total	% of total adult deaths
1	5	12	15	**32**	**3.02%**
2	11	16	29	**56**	**8.48%**
3	27	28	35	**90**	**7.07%**
4	19	31	25	**75**	**7.07%**
5	42	34	40	**116**	**10.93%**
6	49	48	68	**165**	**15.55%**
7	46	40	61	**147**	**13.85%**
8	48	47	44	**139**	**13.10%**
9	34	42	49	**125**	**11.78%**
10	35	34	40	**109**	**10.27%**
Missing	2	2	3	**7**	**0.66%**
UHSx Q3 Total	**318**	**334**	**409**	**1061**	
No. in most deprived postcodes (D1-4)	**62**	**87**	**104**	**253**	
% in most deprived postcodes (D1-4)	**19.50%**	**26.05%**	**25.43%**	**23.85%**	

October to December 2024

- **23.85% (253)** of adult deaths related to those within most deprived postcodes (D1-4); decrease from **24.70% (228)** in 2024/25 Q2.
- The highest number of adult deaths related to D6 at **15.55% (165);** decrease from **17.12% (158)** in 2024/25 Q2.
- **30.77% (20)** of SJR referrals related to postcodes D1-4; increase from **27.35% (32)** in 2024/25 Q2.
- The highest number of SJR referrals related to D8 and D10 **(both 13.85%, 9)** This represents a shift from D6 - **16.24% (19)** in 2024/25 Q2. D6 **10.77% (7)** this quarter.

Demographics for SJR Referrals					
	Oct-24	Nov-24	Dec-24	UHSx Q3 Total	% of all SJR referrals
1	1	1	1	**3**	**4.62%**
2	1	1	3	**5**	**7.69%**
3	3	1	3	**7**	**10.77%**
4	0	4	1	**5**	**7.69%**
5	4	0	2	**6**	**9.23%**
6	1	2	4	**7**	**10.77%**
7	1	3	2	**6**	**9.23%**
8	2	2	5	**9**	**13.85%**
9	2	2	2	**6**	**9.23%**
10	3	2	4	**9**	**13.85%**
Missing	0	1	1	**2**	**3.08%**
UHSx Q3 Total	**18**	**19**	**28**	**65**	
No. in most deprived postcodes (D1-4)	**5**	**7**	**8**	**20**	
% in most deprived postcodes (D1-4)	**27.78%**	**36.84%**	**28.57%**	**30.77%**	

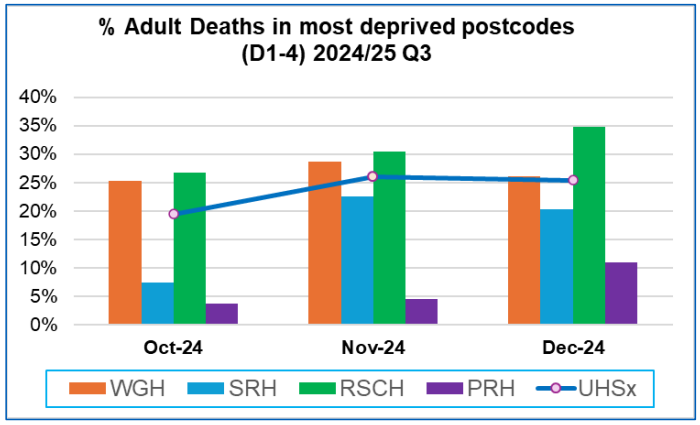
Learning from Death Mortality Demographics - 2024/25 Q3

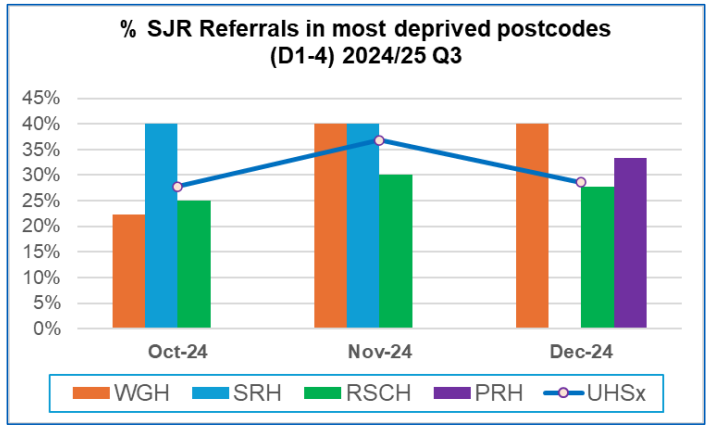
Deaths by IMD Decile (1 = most deprived, 10 = least deprived) Breakdown by hospital site

NHS University Hospitals Sussex NHS Foundation Trust

All Adult Deaths - Most deprived postcodes (D1-4)						
	WGH	SRH	RSCH	PRH	UHSx	% in most deprived postcode
Oct-24	25	6	30	1	**62**	**19.50%**
Nov-24	29	21	36	1	**87**	**26.05%**
Dec-24	29	22	47	6	**104**	**25.43%**
Q3 Total	**83**	**49**	**113**	**8**	**253**	**23.85%**

SJR Referrals - Most deprived postcodes (D1-4)						
	WGH	SRH	RSCH	PRH	UHSx	% in most deprived postcode
Oct-24	2	2	1	0	**5**	**27.78%**
Nov-24	2	2	3	0	**7**	**36.84%**
Dec-24	2	0	5	1	**8**	**28.57%**
Q3 Tota	**6**	**4**	**9**	**1**	**20**	**30.77%**





% Adult Deaths in most deprived postcodes (D1-4)					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	25.25%	7.50%	26.79%	3.70%	19.50%
Nov-24	28.71%	22.58%	30.51%	4.55%	26.05%
Dec-24	26.13%	20.37%	34.81%	10.91%	25.43%
Q3 Total	**26.69%**	**17.44%**	**30.96%**	**7.69%**	**23.85%**

% SJR Referrals in most deprived postcodes (D1-4)					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	22.22%	40.00%	25.00%		27.78%
Nov-24	40.00%	40.00%	30.00%		36.84%
Dec-24	40.00%	0.00%	27.78%	33.33%	28.57%
Q3 Total	**31.58%**	**36.36%**	**28.13%**	**33.33%**	**30.77%**

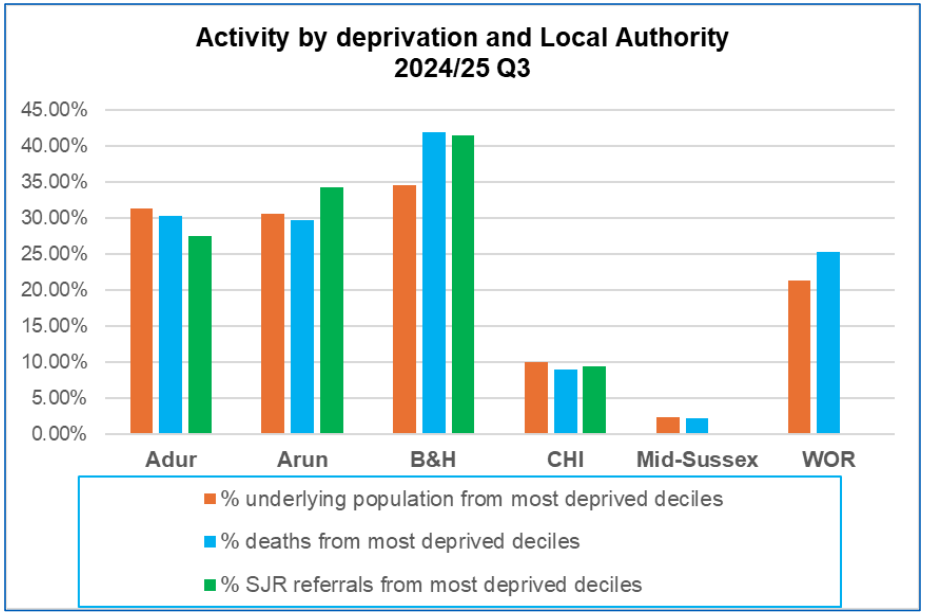
Learning from Death Mortality Demographics - 2024/25 Q3

University Hospitals Sussex NHS Foundation Trust

Deaths by IMD Decile (1 = most deprived, 10 = least deprived)

Local Authority overview

Activity by deprivation and Local Authority	Adur	Arun	B&H	CHI	Mid-Sussex	WOR
% underlying population from most deprived deciles	31.28%	30.55%	34.54%	10.02%	2.25%	21.38%
% deaths from most deprived deciles	30.36%	29.80%	41.93%	8.87%	2.19%	25.25%
% SJR referrals from most deprived deciles	27.59%	34.29%	41.49%	9.38%	0.00%	0.00%



Key Observations

- **Arun and Brighton & Hove**: More deaths in most deprived deciles than expected based on underlying population. Higher number of referrals for SJR.
- **Adur and Chichester:** Less referrals from most deprived deciles than in underlying populations, indicative of access issues.
- **Mid Sussex and Worthing:** Very small percentage of deaths in most deprived postcodes. IMD Decile information missing for 2024/25 Q3 SJR referrals (15 Mid Sussex, 10 Worthing.)

Learning from Death Mortality Deaths by Age Group - 2024/25 Q3

Breakdown of adult deaths by age group

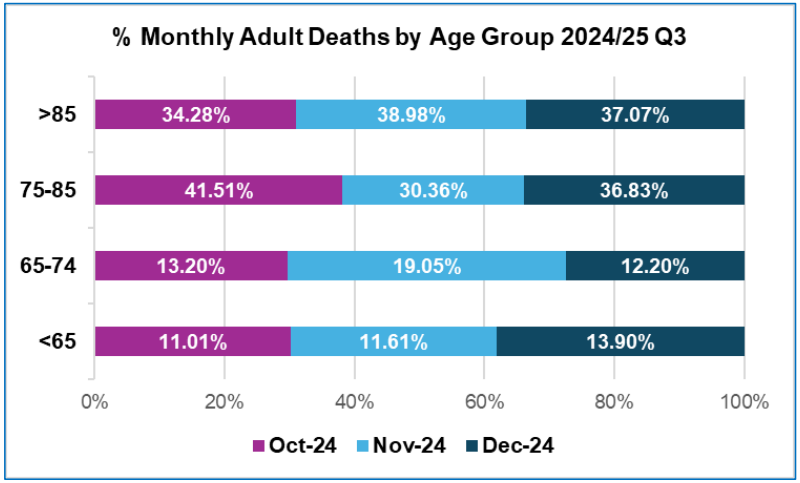
NHS Hospitals Sussex NHS Foundation Trust

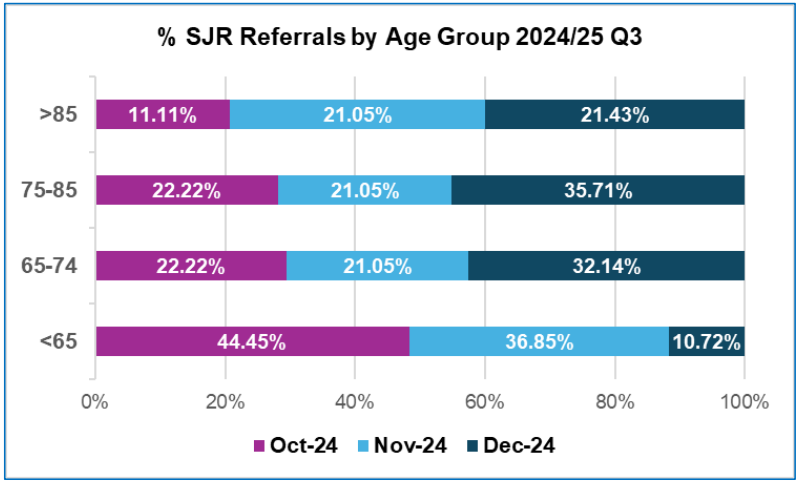
% Adult Deaths by Age Group			
Age	**Oct-24**	**Nov-24**	**Dec-24**
<65	11.01%	11.61%	13.90%
65-74	13.20%	19.05%	12.20%
75-85	41.51%	30.36%	36.83%
>85	34.28%	38.98%	37.07%

Key Observations

- Highest proportion of **acute** adult deaths consistently in over 75+ age groups.
- Most adult deaths in 75-85 age group occurred in the month of October 2024 **(41.51%)**
- Even dispersal of adult deaths in over 85 age group across monthly Q3 period.
- Highest number of SJR referrals in under 65 age group in the month of October 2024 (**44.45%)**

% SJR Referrals by Age Group			
Age	**Oct-24**	**Nov-24**	**Dec-24**
<65	44.45%	36.85%	10.72%
65-74	22.22%	21.05%	32.14%
75-85	22.22%	21.05%	35.71%
>85	11.11%	21.05%	21.43%



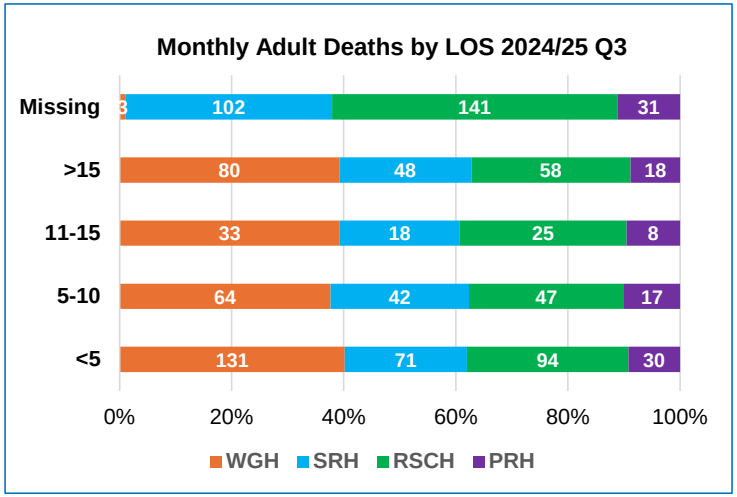


Learning from Death Mortality Deaths by Length of Stay (LOS) - 2024/25 Q3

Breakdown of adult deaths by Length of Stay (by number of days)

NHS Hospitals Sussex NHS Foundation Trust

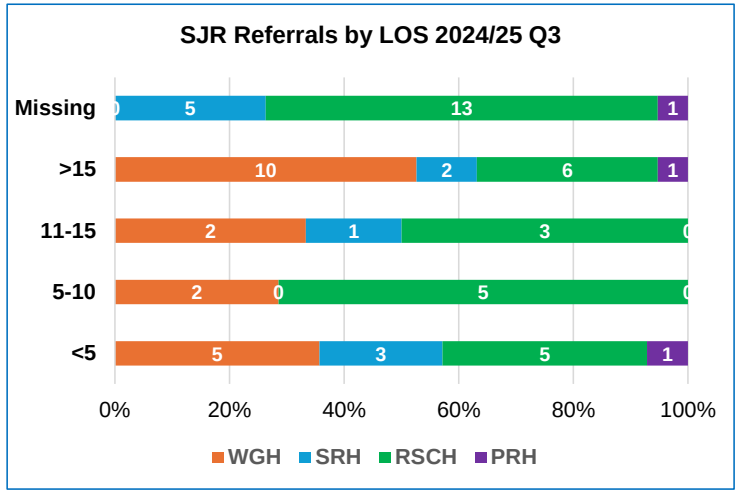
Adult Deaths by LOS						
No. of Days	WGH	SRH	RSCH	PRH	UHSx Q3 Total	% of total adult deaths
<5	131	71	94	30	**326**	**30.73%**
5-10	64	42	47	17	**170**	**16.02%**
11-15	33	18	25	8	**84**	**7.92%**
>15	80	48	58	18	**204**	**19.23%**
Missing	3	102	141	31	**277**	**26.11%**
Q3 Total	**311**	**281**	**365**	**104**	**1061**	



Key Observations

- **326 (30.73%)** of adult deaths where LOS was less than 5 days.
- The highest number of SJR referrals related to inpatient stays of greater than 15 days **(19, 29.23%.)**
- LOS could not be calculated for **277 (26.11%)** of adult deaths and **19 (29.23%)** SJR referrals because date of admission was missing from the ME Referral form. This will be fed back to clinical teams.

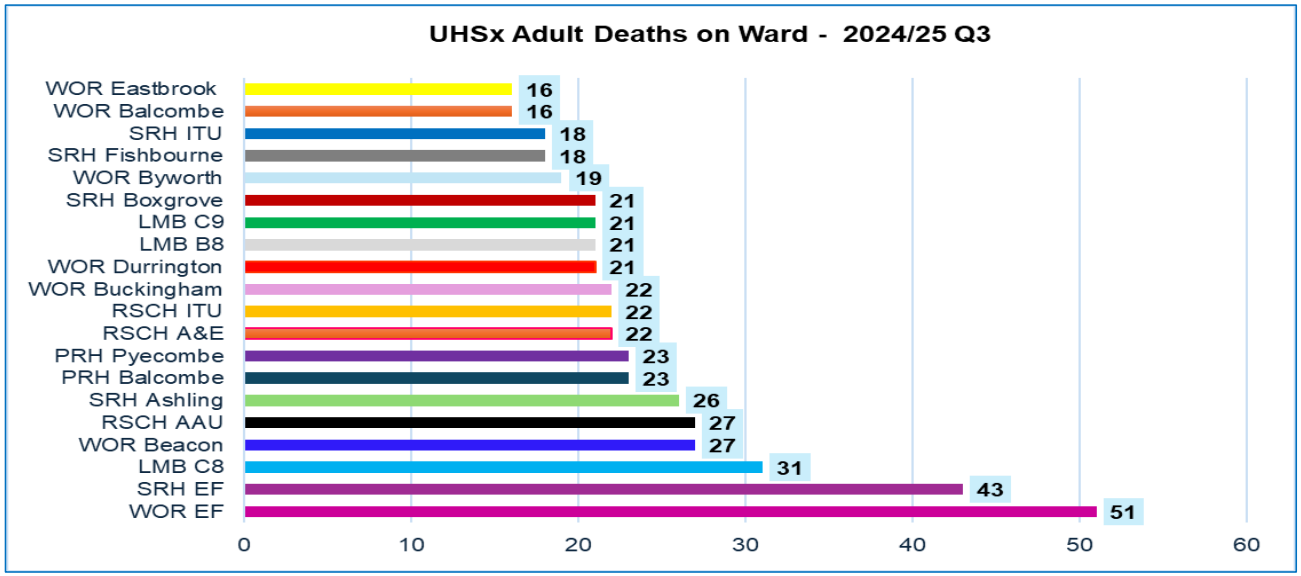
SJR Referrals by LOS						
No. of Days	WGH	SRH	RSCH	PRH	UHSx Q3 Total	% of all SJR referrals
<5	5	3	5	1	**14**	**21.54%**
5-10	2	0	5	0	**7**	**10.77%**
11-15	2	1	3	0	**6**	**9.23%**
>15	10	2	6	1	**19**	**29.23%**
Missing	0	5	13	1	**19**	**29.23%**
Q3 Total	**19**	**11**	**32**	**3**	**65**	



Learning from Death Mortality Deaths by Ward - 2024/25 Q3

Breakdown of adult deaths by ward (by highest number of deaths.)

Adult Deaths on Ward 2024/25 Q3			
Adult Deaths on Ward (order of incidence)	**No. of deaths**	**% of site specific deaths**	**% of all adult deaths**
WOR EF	51	16.40%	**4.81%**
SRH EF	43	15.30%	**4.05%**
LMB C8	31	8.49%	**2.92%**
WOR Beacon	27	8.68%	**2.54%**
RSCH AAU	27	7.40%	**2.54%**
SRH Ashling	26	9.25%	**2.45%**
PRH Balcombe	23	22.12%	**2.17%**
PRH Pyecombe	23	22.12%	**2.17%**
RSCH A&E	22	6.03%	**2.07%**
RSCH ITU	22	6.03%	**2.07%**
WOR Buckingham	22	7.07%	**2.07%**
WOR Durrington	21	6.75%	**1.98%**
LMB B8	21	5.75%	**1.98%**
LMB C9	21	5.75%	**1.98%**
SRH Boxgrove	21	7.47%	**1.98%**
WOR Byworth	19	6.11%	**1.79%**
SRH Fishbourne	18	6.41%	**1.70%**
SRH ITU	18	6.41%	**1.70%**
WOR Balcombe	16	5.14%	**1.51%**
WOR Eastbrook	16	5.14%	**1.51%**

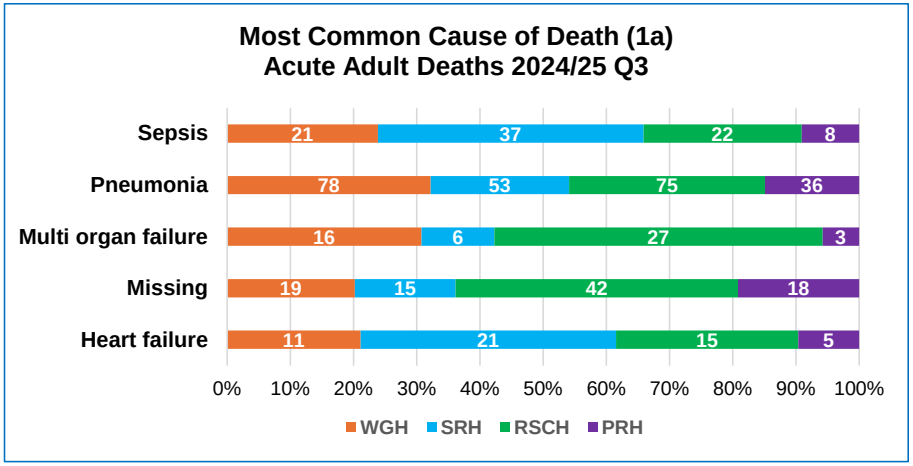


Key Observations

- High number of adult deaths across Worthing EF, SRH EF, RSCH AAU, RSCH A&E and RSCH ITU (**165, 15.55%** of all adult deaths across UHSx.)
- **51** adult deaths in **Worthing EF** which equates to **16.40%** of deaths at Worthing; **4.81%** across UHSx (increase from 2024/25 Q2, **13.62%; 4.44%**)
- At **PRH**, the highest number of deaths occurred on **Balcombe** and **Pyecombe, both 22.12%** of adult deaths at PRH; **2.17%** across UHSx. Balcombe % across UHSx unchanged from 2024/25 Q2.

Learning from Death Mortality Cause of Death - 2024/25 Q3

Top 5 common causes of acute adult deaths (1a on MCCD)



Most Common Cause of Death (1a)
Acute Adult Deaths 2024/25 Q3

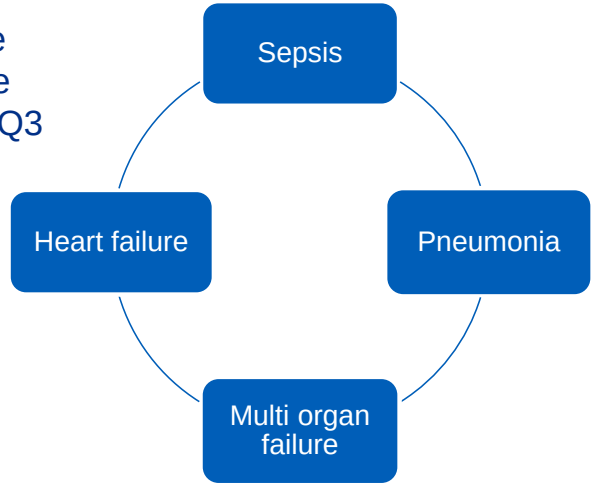
	WGH	SRH	RSCH	PRH	UHSx	% of all Adult Deaths
Heart failure	11	21	15	5	52	**4.90%**
Missing	19	15	42	18	94	**8.86%**
Multi organ failure	16	6	27	3	52	**4.90%**
Pneumonia	78	53	75	36	242	**22.81%**
Sepsis	21	37	22	8	88	**8.29%**
Q3 Total	**145**	**132**	**181**	**70**	**528**	**49.76%**

Note: Heart failure and pneumonia were jointly listed on 1a for 9 patients. These have therefore been double-counted.

October to December 2024

- **22.81% (242)** of all **acute** adult deaths had **pneumonia** listed as 1a on the MCCD; increase from **12.78% (118)** in 2024/25 Q2. This is an expected seasonal finding.
- Top 4 common causes of deaths on MCCDs were **pneumonia, sepsis, heart failure and multi organ failure** These accounted for **40.90% (434)** of all **acute** adult deaths.
- **94 (8.86%)** of cases had no given cause(s) of death on the ME form.

Pneumonia was the most common cause of death in 2024/25 Q3

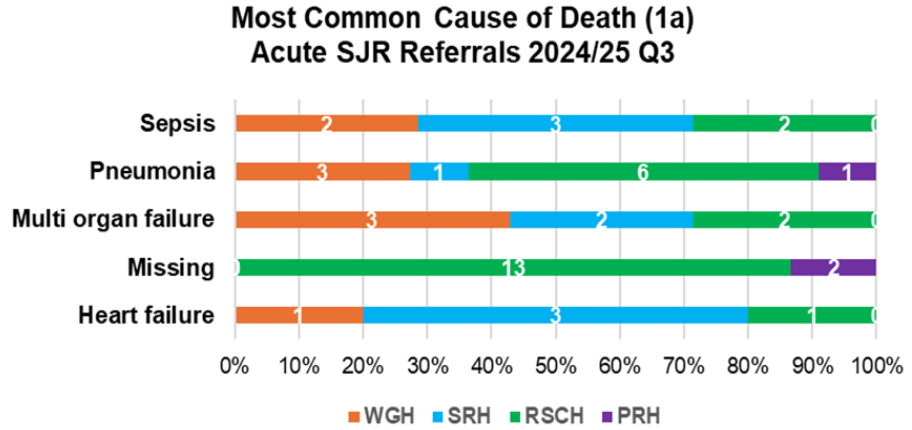


Learning from Death Structured Judgement Review (SJR) Referrals - 2024/25 Q3

Breakdown of cases referred to SJR including top common causes of acute adult deaths (1a on MCCD.)

University Hospitals Sussex NHS Foundation Trust

Adult Deaths Referred for SJR						
	WGH	SRH	RSCH	PRH	UHSx	% of all Deaths referred for SJR
Oct-24	9	5	4	0	18	**5.66%**
Nov-24	5	4	10	0	19	**5.69%**
Dec-24	5	2	18	3	28	**6.85%**
Q3 Total	**19**	**11**	**32**	**3**	**65**	
% of all Deaths referred for SJR	**6.11%**	**3.91%**	**8.77%**	**2.88%**	**6.13%**	



October to December 2024

- **65 (6.13%)** adult **acute** deaths referred for SJR - decrease from **148 (12.62%)** on 2023/24 Q3; decrease from **117 (12.68%)** in 2024/25 Q2.
- The highest number of SJR referrals received related to adult deaths at **RSCH (32, 8.77%)** - decrease from **57 (18.15%)** in 2024/25 Q2.
- **23.08% (15)** SJR referrals had no given cause(s) of death on the form; increase from **18.80% (22)** in 2024/25 Q2.
- **16.92% (11)** SJR referrals had **pneumonia** listed as 1a on the MCCD; increase from **10.26% (12)** in 2024/25 Q2.

Most Common Cause of Death (1a) Acute SJR Referrals 2024/25 Q3						
	WGH	SRH	RSCH	PRH	UHSx	% of SJR referrals
Heart failure	1	3	1	0	5	**7.69%**
Missing	0	0	13	2	15	**23.08%**
Multi organ failure	3	2	2	0	7	**10.77%**
Pneumonia	3	1	6	1	11	**16.92%**
Sepsis	2	3	2	0	7	**10.77%**
Q3 UHSx Total	**9**	**9**	**24**	**3**	**45**	**69.23%**

Learning from Death Structured Judgement Review (SJR) Data - 2024/25 Q3

SJR completed by hospital site/SJR outstanding as of 31/12/2024.

University Hospitals Sussex NHS Foundation Trust

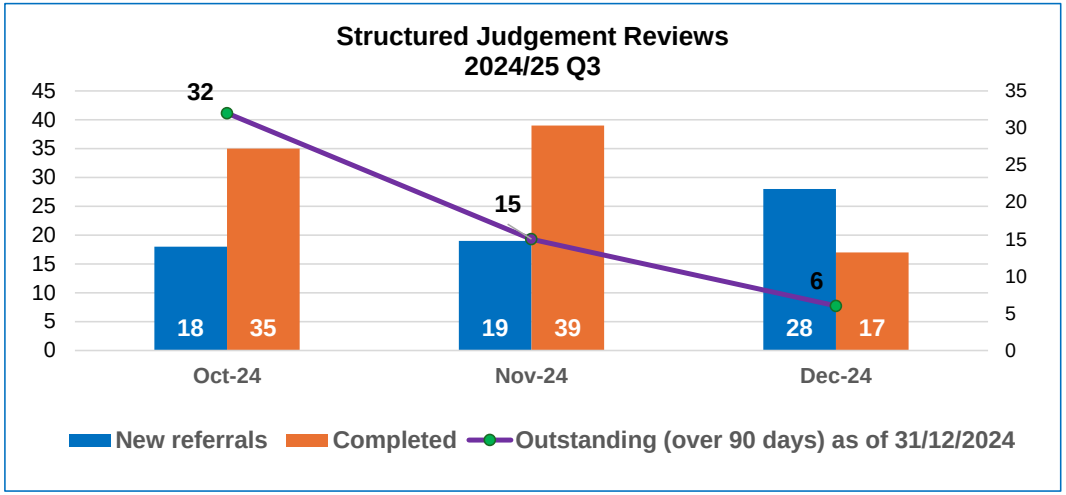
Structured Judgement Review Progress				
	Oct-24	Nov-24	Dec-24	UHSx
New referrals	18	19	28	**65**
Completed	35	39	17	**91**
Outstanding (over 90 days) as of 3	32	15	**6**	

SJRs Completed 2024/25 Q3					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	14	5	13	3	**35**
Nov-24	16	6	16	1	**39**
Dec-24	2	3	11	1	**17**
Q3 Total	**32**	**14**	**40**	**5**	**91**

SJRs Completed within 90 Days					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	8	1	1	0	**10**
Nov-24	7	6	6	0	**19**
Dec-24	2	3	2	0	**7**
Q3 Total	**17**	**10**	**9**	**0**	**36**

All SJRs outstanding over 90 days					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	8	1	21	2	**32**
Nov-24	1	1	12	1	**15**
Dec-24	2	0	4	0	**6**

Referrals received and triaged in month as Not Required					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	9	3	12	6	**30**
Nov-24	4	2	13	3	**22**
Dec-24	3	0	11	3	**17**
Q3 Total	**16**	**5**	**36**	**12**	**69**



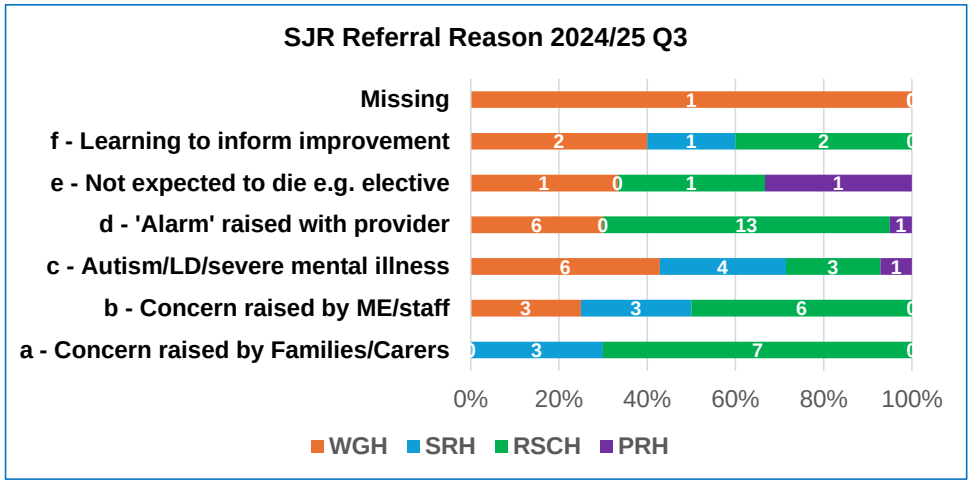
October to December 2024

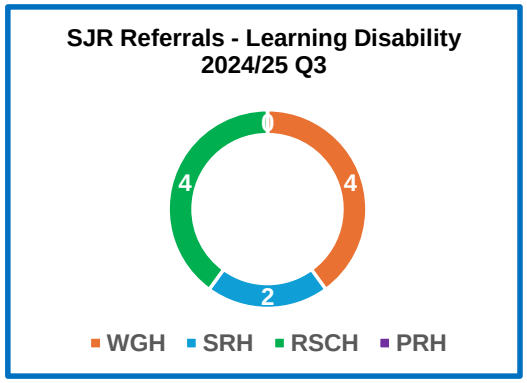
- **91** SJRs completed, three times more than in 2023/24 Q3 (**28**); decrease from **150** in 2024/25 Q2 (can be attributed to SJR referral triage.)
- **36** SJRs completed within 90 days, three times more than in 2023/24 Q3 **(12)**; decrease from **46** in 2024/25 Q2 (can be attributed to winter pressures, Christmas/New Year leave.)
- **6** SJRs outstanding over 90 days **as of 31/12/2024**; significant decrease from **123** on 30/09/2024.
- **As of 31/12/2024** oldest open SJR referral **January 2024.**.

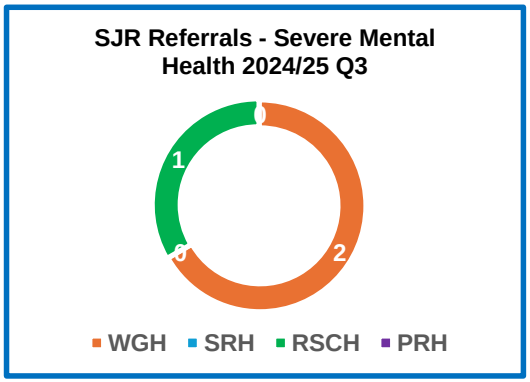
Learning from Death Structured Judgement Review Referrals - 2024/25 Q3

University Hospitals Sussex NHS Foundation Trust

SJR referrals may be received from the ME office, DQSM, Medico-Legal and/or Patient Safety







SJR Referral Reason						
	WGH	SRH	RSCH	PRH	UHSx	% total adult deaths referred for SJR
a - Concern raised by Families/Carers	0	3	7	0	10	**15.38%**
b - Concern raised by ME/staff	3	3	6	0	12	**18.46%**
c - Autism/LD/severe mental illness	6	4	3	1	14	**21.54%**
d - 'Alarm' raised with provider	6	0	13	1	20	**30.77%**
e - Not expected to die e.g. elective	1	0	1	1	3	**4.62%**
f - Learning to inform improvement	2	1	2	0	5	**7.69%**
Missing	1	0	0	0	1	**1.54%**
Q3 UHSx Total	**19**	**11**	**32**	**3**	**65**	

October to December 2024

- **'Alarm' raised with provider** was the highest reason for SJR referrals at **30.77% (20.)**
- **15.38% (10)** referred due to **Concern raised by ME/staff**; decrease from **31.62% (37)** in 2024/25 Q2.
- **10 (15.38%)** Learning Disability referrals; decrease from 6 2023/24 Q3; increase from **8 (6.84%)** in 2024/25 Q2.
- **3 (4.62%)** Severe Mental Health referrals; decrease from **5** in 2023/24 Q3; decrease from **5 (4.27%)** in 2024/25 Q2.
- **21.54% (14)** referrals under category C (autism/LD/severe mental illness); increase from **11.11% (13)** in 2024/25 Q2 (can be attributed to SJR referral triage.)

Learning from Death SJR Mortality Panel Outcome Scores - 2024/25 Q3

Mortality Panel scores following completion of SJRs by SJR Reviewers.

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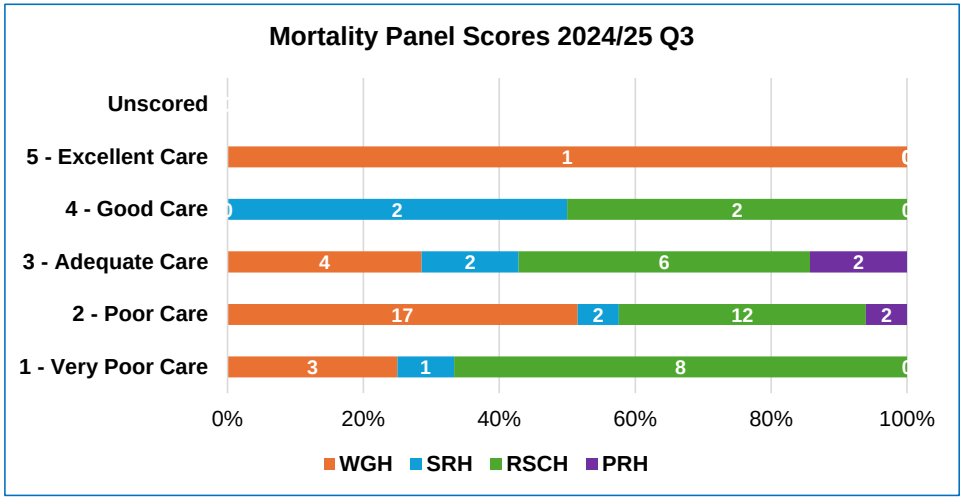


Mortality Panel Scores 2024/25 Q3						
	WGH	SRH	RSCH	PRH	UHSx	% Reviewed
1 - Very Poor Care	3	1	8	0	12	**18.75%**
2 - Poor Care	17	2	12	2	33	**51.56%**
3 - Adequate Care	4	2	6	2	14	**21.88%**
4 - Good Care	0	2	2	0	4	**6.25%**
5 - Excellent Care	1	0	0	0	1	**1.56%**
Unscored	0	0	0	0	0	**0.00%**
Q3 UHSx Total	**25**	**7**	**28**	**4**	**64**	

October to December 2024

- **64** SJRs reviewed at Panel (decrease from **105** in 2024/25 Q2.) Multifactorial - SJR referral triage, winter pressures, Christmas/New Year leave.
- **70.31% (45)** of SJRs reviewed at Panel scored **1 (Very Poor Care)** or **2 (Poor Care)**; increase from **54.29% (57)** in 2024/25 Q2.
- **51.56% (33)** of SJRs reviewed at Panel scored **2 (Poor Care)**; increase from **34.29% (36)** in 2024/25 Q2.
- **92.19% (59)** of all SJRs reviewed **scored between 1 and 3**; increase from **77.14% (81)** in 2024/25 Q2 (can be attributed to SJR referral triage.)
- Increases can be attributed to SJR referral triage.
- **1 (1.56%)** scored **5 - Excellent Care**; **0** in 2024/25 Q2.

A Panel of SJR Reviewers and the Mortality & Learning from Deaths Manager review completed SJRs with a score of **1 (Very Poor Care)** or **2 (Poor Care.)** In addition, a random selection of cases that score **3 (Adequate Care)** occurs, to ensure appropriate governance and continuous SJR Reviewer learning/calibration.

Learning from Death SJR Mortality Panel Identification of Harm - 2024/25 Q3

NHS University Hospitals Sussex NHS Foundation Trust

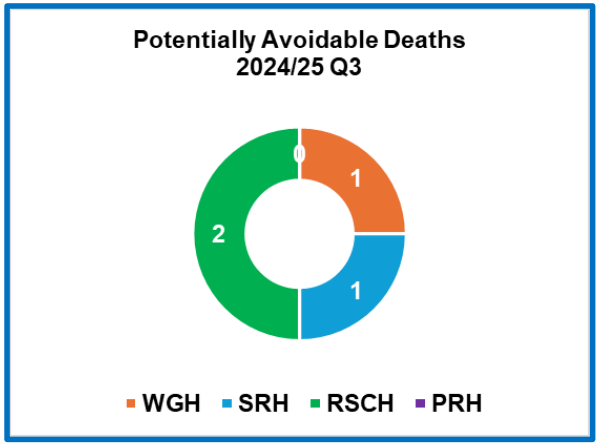
Cases where the Panel identifies that the death may have been avoidable.

October to December 2024

- **4 (6.25%)** cases identified by the Panel as '**may have been avoidable**' (increase from **1** in 2023/24 Q3; decrease from **6 (5.71%)** in 2024/25 Q2.)
- As of 13/01/2024, **2** cases have been downgraded to low harm. **2** remain under review.
- **2** cases related to deaths at **RSCH**; **1** at **WGH** and **1** at **SRH**.
- The single case at SRH accounted for **14.29%** of SJRs reviewed at Panel pertaining to SRH.

Potentially Avoidable Deaths Identified by Mortality Panel						
	WGH	SRH	RSCH	PRH	UHSx	%Reviewed
Oct-24	0	0	2	0	**2**	**8.70%**
Nov-24	1	1	0	0	**2**	**6.25%**
Dec-24	0	0	0	0	**0**	**0.00%**
Q3 Total	**1**	**1**	**2**	**0**	**4**	
%Reviewed	**4.00%**	**14.29%**	**7.14%**	**0.00%**	**6.25%**	

Case No.	Site	DoD	Mortality Panel Date	Update
1	RSCH	10/07/2022	15/10/2024	Downgraded to low harm Coroner concluded natural death
2	RSCH	19/06/2024	29/10/2024	Under review by Division
3	WGH	28/10/2023	14/11/2024	Downgraded to low harm
4	SRH	06/07/2024	19/11/2024	Under review by Division



Learning from Death SJR Mortality Panel Identification of Harm - 2024/25 Q3

A Datix will be raised where the Panel identifies moderate harm or that the death may have been avoidable.

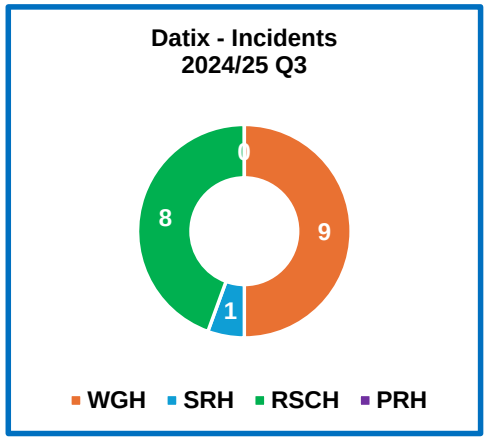
University Hospitals Sussex NHS Foundation Trust

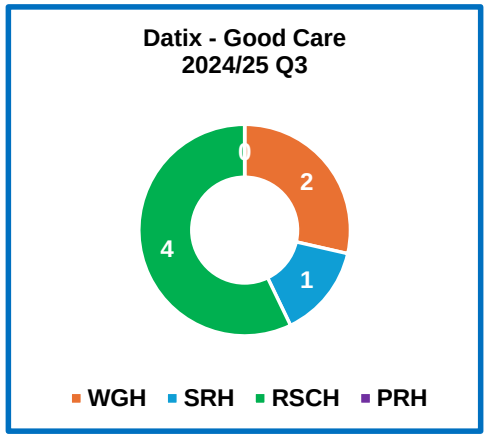
October to December 2024

- **18 (28.13%)** Datix's raised following Panel identifying harm (significant increase from **9** in 2023/24 Q3; decrease from **42 (40%)** in 2024/25 Q2. Increase from 2023/24 accounted for by new SJR model, with higher number of SJRs being completed and reviewed at Panel.
- **7 (10.94%)** Datixes raised to share positive learning from **Good Care**; increase from **4 (3.42%)** in 2024/25 Q1; not completed in Q2 as SJR referral triage prioritised.
- Most problems in care continue to be identified during **ongoing** and **end of life phases of care.**

SJRs that resulted in Incident DATIX post-Mortality Panel						
	WGH	SRH	RSCH	PRH	UHSx	%Reviewed
Oct-24	5	0	3	0	8	34.78%
Nov-24	1	1	4	0	6	18.75%
Dec-24	3	0	1	0	4	44.44%
Q3 Total	9	1	8	0	18	
%Reviewed	36.00%	14.29%	28.57%	0.00%	28.13%	

SJRs that resulted in Good Care DATIX post-Mortality Panel						
	WGH	SRH	RSCH	PRH	UHSx	%Reviewed
Oct-24	1	0	0	0	1	4.35%
Nov-24	0	0	2	0	2	6.25%
Dec-24	1	1	2	0	4	44.44%
Q3 Total	2	1	4	0	7	
%Reviewed	8.00%	14.29%	14.29%	0.00%	10.94%	





Learning from Death SJR Mortality Panel Learning Themes - 2024/25 Q3

Ambition: Excellent outcomes, robust mortality review process to evidence the delivery of high standard of care to patients.

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Top 10 learning themes identified

- Delay to diagnosis/treatment
- Delay to/no DNACPR/TEP
- Delay to/no palliative care team involvement/EOLC decision-making
- Delay to/no senior input/review
- Delay in recognising deteriorating patient
- Unplanned readmission/poor discharge planning.
- Lack of advanced care planning
- Lack of patient monitoring
- Poor communication with family/NOK
- Unnecessary investigations.

Top 3 positive learning themes identified

- Early recognition of deterioration with appropriate management
- Good EOLC and communication with family/NOK.
- Good decision making and involvement of palliative care team.

Learning themes identified where Panel felt death may have been avoidable

- CPR despite DNACPR
- Delay in acting on investigation results
- Delay in recognising deteriorating patient
- Inadequate/lack of comfort measures
- Lack of advanced care planning
- Lack of specialist input
- Poor record-keeping.

Key Observations

- **Discharge planning, EOLC (lack of TEP and/or DNACPR) and delayed recognition of deteriorating patient** remain recurrent themes.
- Increased incidence where CPR has been given despite a DNACPR in place (community and/or acute.)
- Increased incidence of hospital transfer despite no plan for active intervention.

Medical Examiner Office Update - Updates, Observations & Concerns - 2024/25 Q3

New regulations governing Medical Examiners took effect in England and Wales on 09 September 2024.

University Hospitals Sussex NHS Foundation Trust

Updates:

- Substantive 0.6 WTE SRH-WGH MEO started w/c 6th January.
- Provisional start date (20th January) agreed for maternity cover 0.6 WTE RSCH-PRH MEO.
- Interviews for substantive 0.8 WTE RSCH-PRH MEO planned 27th January.
- 0.4 WTE SRH-WH MEO out to advert.
- Recruitment underway for 2 x 1 PA MEs at SRH-WGH and 3 x 1 PA MEs at RSCH-PRH (within NHSE pay envelope), to support increased workload/following resignations.
- Datix IQ ME demonstration planned 20th January.

Observations & Concerns:

- Significant ME/MEO capacity issues due to staffing levels and high number of referrals in December 2024.
- Time lag between deaths in the community and ME notification continues.
- Concerns some GP practices sharing third-party redacted records - escalated to National Team.
- No suitable office space identified at SRH to co-locate ME, Bereavement and PALS teams - escalated to Property Management Team.

Medical Examiner Office Update - Acute Inpatient Data - 2024/25 Q3

Information provided by RSCH-PRH and SRH-WGH Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

Adult Deaths (Acute)		Scrutinised (No.)	Scrutinised (%)	Average time taken to complete MCCD (Days from referral to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)
Oct-24	**WGH**	99	100.00%	1.4	8	8.08%	3	3.03%	37.50%
	SRH	80	100.00%	1.4	14	17.50%	11	13.75%	78.57%
	RSCH	112	100.00%	2.7	17	15.18%	9	8.04%	52.94%
	PRH	27	100.00%	2.1	7	5.19%	6	22.22%	85.71%
		318	**100.00%**	**1.9**	**46**	**14.47%**	**29**	**9.12%**	**63.04%**
Nov-24	**WGH**	101	100.00%		12	11.88%	6	5.94%	50.00%
	SRH	93	100.00%		20	21.51%	8	8.60%	40.00%
	RSCH	118	100.00%		30	25.42%	21	17.80%	70.00%
	PRH	22	100.00%		3	13.64%	2	9.09%	66.67%
		334	**100.00%**		**65**	**19.46%**	**37**	**11.08%**	**56.92%**
Dec-24	**WGH**	111	100.00%		13	11.71%	5	4.50%	38.46%
	SRH	108	100.00%		14	12.96%	8	7.41%	57.14%
	RSCH	127	94.07%						
	PRH	54	98.15%						
		400	**98.06%**		**27**	**6.60%**	**13**	**3.18%**	**48.15%**
Q3 Total UHSx		**1052**	**99.35%**	**1.9**	**138**	**13.12%**	**79**	**7.45%**	**57.25%**

Note: BCI non-scrutiny of 'obvious' HMC referrals for inquest, e.g. Road Traffic Collisions

Note: Delay with RSCH-PRH December 2024 data due to ME service capacity issues.

October to December 2024

- **99.35%** adult deaths scrutinised (increase from **99.57%** in 2023/24 Q3; decrease from **100%** in 2024/25 Q2.) **9** RSCH-PRH cases not scrutinised due to BCI.
- Average time taken from referral to issuing MCCD **1.9 days** in October 2024 . November and December 2024 data awaited.
- **138* (13.12%)** adult deaths referred to Coroner (**22.27%** in 2023/24 Q3; **205 (22.21%)** in 2024/25 Q2.)
- Of those referred to Coroner, **79* (57.25%)** investigated (**51.50%** in 2023/24 Q3; **101 (49.93%)** in 2024/25 Q2.)
- **7.45%*** of adult deaths investigated by Coroner (**11.17%** in 2023/24 Q3; **10.94%** in 2024/25 Q2.)

***RSCH-PRH December 2024 data will be updated as soon as possible. Delay due to capacity issues**. Narrative should therefore be treated with caution.

Medical Examiner Office Update - Community Inpatient Data - 2024/25 Q3

Information provided by RSCH-PRH and SRH-WGH Lead MEOs, on behalf of independent ME Service.

University Hospitals Sussex NHS Foundation Trust

Adult Deaths (Community)		Scrutinised (No.)	Scrutinised (%)	Average time taken to complete MCCD (Days from referral to sending)	Referred to Coroner (No.)	Referred to Coroner (% of total adult deaths)	Investigated by Coroner (No.)	Investigated by Coroner (% of total adult deaths)	Investigated by Coroner (% of referred to Coroner)
Oct-24	West Sussex	325	100.00%	1.6	21	6.46%	6	1.85%	0.00%
	Brighton & Mid Sussex	119	100.00%	2.8	8	6.72%	2	1.68%	25.00%
		444	**100.00%**	**2.2**	**29**	**6.53%**	**8**	**1.80%**	**27.59%**
Nov-24	West Sussex	274	100.00%	1.8	31	11.31%	4	1.46%	12.90%
	Brighton & Mid Sussex	92	100.00%	3.0	5	5.43%	1	1.09%	20.00%
		366	**100.00%**	**2.4**	**36**	**9.84%**	**5**	**1.37%**	**13.89%**
Dec-24	West Sussex	308	100.00%		35	11.36%	11	3.57%	31.43%
	Brighton & Mid Sussex								
		308	**100.00%**		**35**	**3.13%**	**11**	**3.57%**	**31.43%**
Q3 Total		**1118**	**100.00%**	**2.3**	**100**	**8.94%**	**24**	**2.15%**	**24.00%**

October to December 2024

- **1118*** community deaths; **907** occurred in West Sussex and **211*** in Brighton & Mid Sussex; **870** in 2024/25 Q2.
- **100%*** adult deaths scrutinised. December 2024 Brighton & Mid Sussex data awaited.
- **100* (8.94%)** adult deaths referred to Coroner; **59 (6.78%)** in 2024/25 Q2.
- Of those referred to Coroner, **24 (2.15%)** investigated; **18 (30.51%)** in 2024/25 Q2.
- **3.57%***of adult deaths investigated by Coroner; **2.07%** in 2024/25 Q2.

***Brighton & Mid Sussex December 2024 data will be updated as soon as possible. Delay due to capacity issues**. Narrative should therefore be treated with caution.

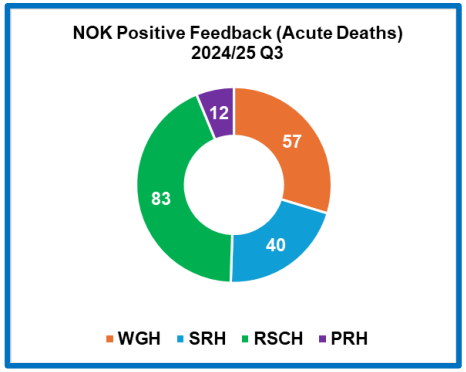
Medical Examiner Office Update - Acute NOK Feedback - 2024/25 Q3

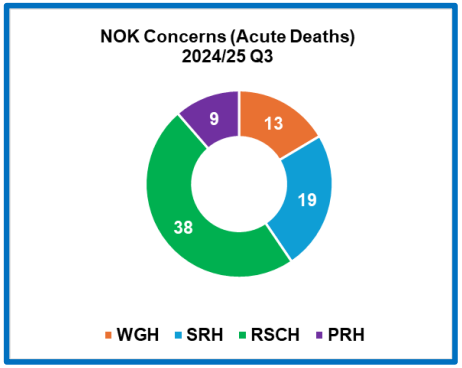
NHS University Hospitals Sussex NHS Foundation Trust

Key concerns raised by families/Next of Kin calls are referred for SJR and learning is identified through the SJR outputs.

October to December 2024

- **192*** positive feedback responses; **211 (79.32%)** in 2023/24 Q3; **181 (73.88%)** in 2024/25 Q2.
- **79*** negative feedback responses; **55 (20.68%)** in 2023/24 Q3; **64 (26.12%)** in 2024/25 Q2.
- Recurrent feedback related to **communication** and **quality of care**.





Top 5 positive themes:

- Clinical decision-making
- Good discussions regarding ceilings of care
- Good communication
- Good nursing care
- Good quality care

Top 5 concerns raised:

- Clinical decision-making
- Delay to treatment
- Discharge planning issues
- Lack of senior input
- Issues around end of life care

***RSCH-PRH December 2024 data will be updated as soon as possible. Delay due to capacity issues**. Narrative should therefore be treated with caution.

Positive Feedback Received from NOK Calls (Acute Deaths)					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	23	16	42	6	**87**
Nov-24	15	8	41	6	**70**
Dec-24	19	16			**35**
Q3 Total	**57**	**40**	**83**	**12**	**192**

Negative Feedback Received/Concerns Raised from NOK Calls (Acute Deaths)					
	WGH	SRH	RSCH	PRH	UHSx
Oct-24	4	3	24	6	**37**
Nov-24	2	8	14	3	**27**
Dec-24	7	8			**15**
Q3 Total	**13**	**19**	**38**	**9**	**79**

Note: RSCH-PRH December 2024 delayed data due to ME service capacity issues.

Medical Examiner Office Update - Community NOK Feedback - 2024/25 Q3

Key concerns raised by families/Next of Kin calls where deaths have occurred in the community.

NHS University Hospitals Sussex NHS Foundation Trust

October to December 2024

- **132*** positive feedback responses.
- **49*** negative feedback responses.
- High incidence of positive feedback regarding support provided by **ME team.**
- Recurrent feedback regarding **GP access issues.**

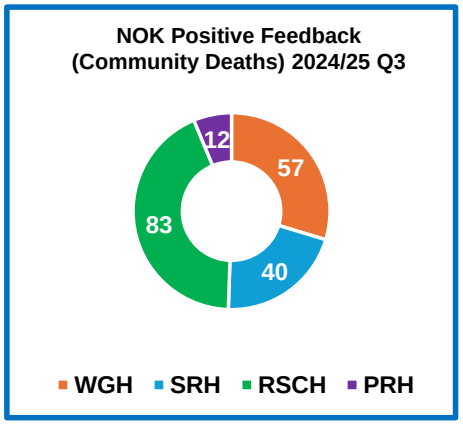
Top 3 positive themes:

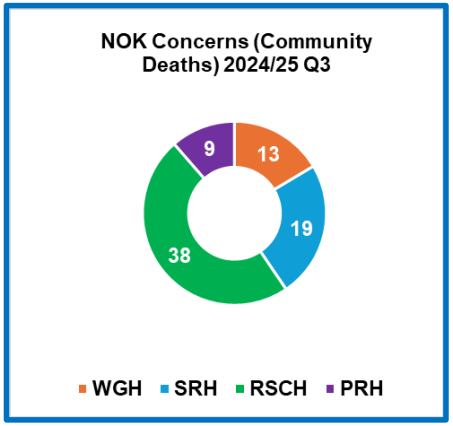
- Good communication
- Good quality care
- Good support from ME team

Top 5 concerns raised:

- Access to GP
- Delay to assessment/treatment
- Delay to MCCD
- Poor communication
- COD given on MCCD

***Brighton & Mid Sussex December 2024 data will be updated as soon as possible. Delay due to capacity issues**. Narrative should therefore be treated with caution.





Positive Feedback Received from NOK Calls (Community Deaths)			
	West Sussex	Brighton & Mid Sussex	Total
Oct-24	0	55	**55**
Nov-24	41	0	**41**
Dec-24	36		**36**
Q3 Total	**77**	**55**	**132**

Negative Feedback Received/Concerns Raised from NOK Calls (Community Deaths)			
	West Sussex	Brighton & Mid Sussex	UHSx
Oct-24	0	7	**7**
Nov-24	28	0	**28**
Dec-24	14		**14**
Q3 Total	**42**	**7**	**49**

Mortality and Learning from Deaths Future Reporting Plan

NHS
University Hospitals Sussex
NHS Foundation Trust

New for Q3

- Adult deaths and SJR referrals by age group.
- Adult deaths and SJR referrals by length of stay.
- Community NOK feedback.

- Reason(s) for referral to Coroner.
- SJR referrals broken down by referrer.
- SJR learning themes broken down by Division.
- Narrative on Mortality Indicators (SHMI/HSMR.)
- Deep dive of SHMI/HSMR outliers.
- Overview of local M&M learning.

Mortality and Learning from Deaths 2024/25 Q3 Report Highlights

NHS University Hospitals Sussex NHS Foundation Trust

ME Scrutiny

- **99.35% acute deaths scrutinised** - **9** RSCH-PRH cases not scrutinised in December 2024 due to BCI.
- **Average time taken from referral to issuing MCCD 1.9 days** in October 2024 **.** November and December 2024 data awaited.
- Significant capacity issues across ME service due to reduced staffing levels and high demand.

SJRs

- **6** SJRs outstanding over 90 days **as of 31/12/2024**; significant decrease from **123** on 30/09/2024.
- **91** SJRs completed, three times more than in 2023/24 Q3 (**28**); decrease from **150** in 2024/25 Q2 - can be attributed to SJR referral triage.
- **36** SJRs completed within 90 days, three times more than in 2023/24 Q3 (**12**); decrease from **46** in 2024/25 Q2 - can be attributed to winter pressures, Christmas/New Year leave.)
- **Top two SJR referral reasons** - **'Alarm' raised with provider 30.77% (20)** and **Autism/LD/severe mental illness 21.54% (14.)**
- **10 (15.38%)** Learning Disability referrals; decrease from **6** 2023/24 Q3; increase from **8 (6.84%)** in 2024/25 Q2.
- **3 (4.62%)** Severe Mental Health referrals; decrease from **5** in 2023/24 Q3; decrease from **5 (4.27%)** in 2024/25 Q2**.**

Mortality and Learning from Deaths 2024/25 Q3 Report Highlights

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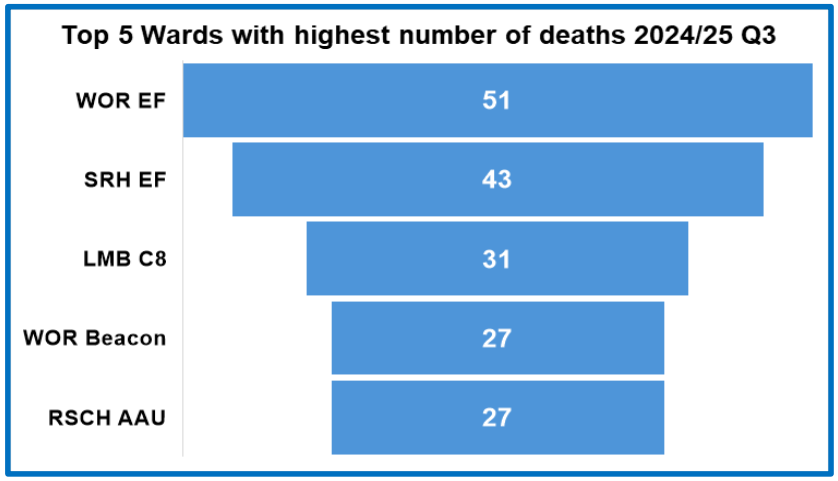

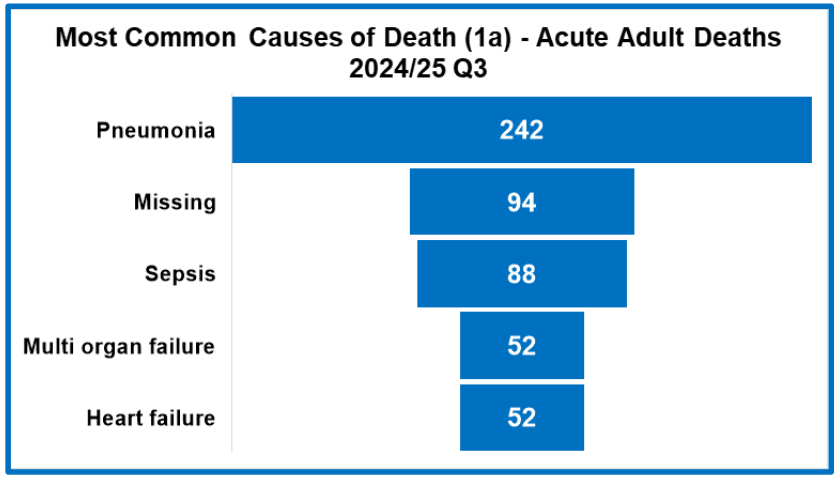

- **165 (15.55%)** **acute** adult deaths across **Worthing EF, SRH EF, RSCH AAU, RSCH A&E** and **RSCH ITU.**
- **51** adult deaths in **Worthing EF** which equates to **16.40%** of deaths at Worthing; **4.81%** across UHSx (increase from 2024/25 Q2, **13.62%; 4.44%)**
- At PRH, the highest number of deaths occurred on **Balcombe** and **Pyecombe**, **both 22.12%** of adult deaths at PRH; **2.17%** across UHSx. Balcombe % across UHSx **unchanged** from 2024/25 Q2.
- **22.81% (242)** of all **acute** adult deaths had **pneumonia** listed as 1a on the MCCD; increase from **12.78% (118)** in 2024/25 Q2 - expected seasonal finding.
- **23.08% (15)** SJR referrals had no given cause(s) of death on the ME referral form; increase from **18.80% (22)** in 2024/25 Q2.

Mortality and Learning from Deaths 2024/25 Q3 Report Highlights

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64 SJRs reviewed at Panel	33 (51.56%) SJRs scored 2 - Poor Care	59 (92.19%) of SJRs scored 1-3	1 (1.56%) scored 5 - Excellent Care
105 in 24/25 Q2	36 in 24/25 Q2	(Very Poor, Poor, Adequate Care)	0 in 24/25 Q2

LfD Update

- Updated LfD Policy ratified and 'live'.
- In process of finalising ToR for Mortality & Morbidity Surveillance Group (MMSG.)
- COE (LfD) Improvement Manager role interviews planned 31st January.

Mortality Panel Outcomes

- **51.56% (33)** of SJRs reviewed at Panel **scored 2 (Poor Care)** - increase from **34.29% (36)** in 2024/25 Q2.
- **92.19% (59)** of all SJRs reviewed **scored between 1 and 3** - increase from **77.14% (81)** in 2024/25 Q2 (can be attributed to SJR referral triage.)
- **1 (1.56%) scored 5 - Excellent Care**; **0** in 2024/25 Q2
- **4 (6.25%)** cases identified by the Panel as **'may have been avoidable'** - increase from **1** in 2023/24 Q3; decrease from **6 (5.71%)** in 2024/25 Q2.
- **18 (28.13%)** Datix's raised following Panel **identifying harm** - increase from **9** in 2023/24 Q3; decrease from **42 (40%)** in 2024/25 Q2.
- **7 (10.94%)** Datixes raised to share positive learning from **Good Care**.

Mortality and Learning from Deaths 2024/25 Q3 Report Highlights

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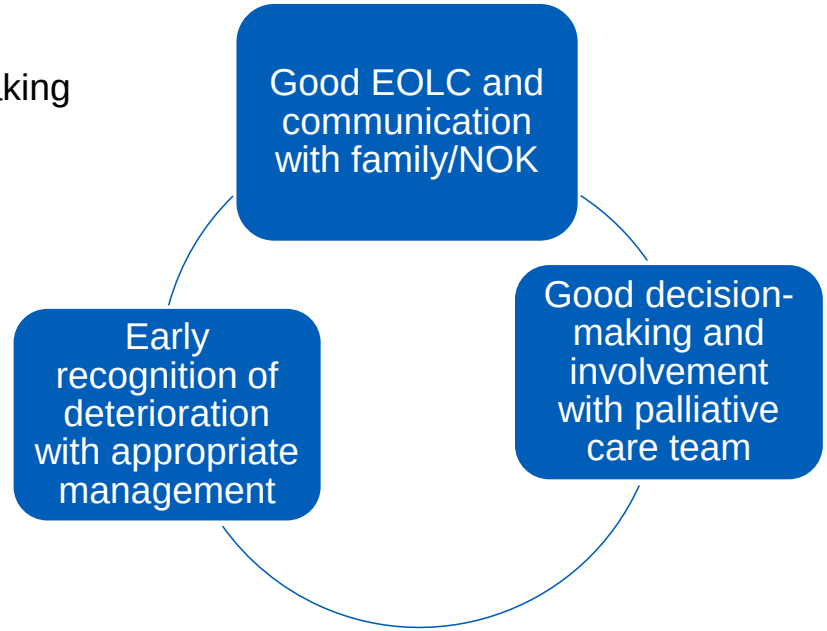
Top 10 SJR Learning Themes

- Delay to diagnosis/treatment
- Delay to/no DNACPR/TEP
- Delay to/no palliative care team involvement/EOLC decision-making
- Delay to/no senior input/review
- Delay in recognising deteriorating patient
- Unplanned readmission/poor discharge planning
- Lack of advanced care planning
- Lack of patient monitoring
- Poor communication with family/NOK
- Unnecessary investigations.

Top 3 Positive SJR Learning Themes



ME Office NOK Feedback/Learning Themes - Acute Deaths

- **192*** **positive** feedback responses - **211 (79.32%)** in 2023/24 Q3; **181 (73.88%)** in 2024/25 Q2.
- **79*** **negative** feedback responses - **55 (20.68%)** in 2023/24 Q3; **64 (26.12%)** in 2024/25 Q2.
- Recurrent NOK feedback (**positive** and **concerns**) related to **communication** and **quality of care**

Mortality and Learning from Deaths 2024/25 Q3 Report Highlights

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Delivering measureable improvements

Learning from #NOF at SRH

Panel Recommendations	Division	Site	Actions Taken
A&E FIB block training to be prioritised.	Medicine	SRH	1. FIB audit presented at patient safety forum. 2. FIB kits on ED trolleys. 3. FIB training provided on an individual basis on the 'shop floor'; it is also mentioned at SHO induction. 4. Move to use ultrasound with plan to deliver more training.

Mortality and Learning from Deaths 2024/25 Q3 Report Highlights

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SJR Reviewer Feedback from LeDeR Panel 02 October 2024

"The Structured Judgement Review (SJR) was very thorough and demonstrated a good understanding of the Mental Capacity Act and best interest decisions."

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Voluntary Services Strategy 2025-2030

Marie McNeil
Head of Voluntary Services

University Hospitals Sussex
NHS Foundation Trust

Contents

The current situation and process for strategic review

1. Voluntary Services in 2024
2. Development of the Strategy: The Theory
3. Development of the Strategy: The Process

The context of the need for a VS Strategy from NHS England

1. Voluntary Services in the NHS England Long Term Workforce Plan
2. NHS England Volunteer Taskforce 4 Key Ambitions
3. NHS England Volunteer Taskforce 4 Recommendations for moving forward

UHSx as an Anchor Institution

1. UHSx as an Anchor Institution
2. UHSx as an Anchor Institution in practice
3. How the Voluntary Services strategy supports the UHSx 5yr strategy

Voluntary Services Strategic & Operational Approach 2025-2030

1. Voluntary Services Strategy: how we will work
2. Voluntary Services Foundations: what the strategy will operationally be built on
3. Voluntary Services UHSx 5 year Strategic Priorities:
4. Governance Assurances: Ensuring compliance and best practice within Voluntary Services
5. Voluntary Services in 2030

Voluntary Services in 2024

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- Head of Voluntary Services started Jan 2024 (18 month contract)
- 3 separate teams coordinating Volunteer activity across the Trust; RSCH & PRH, WaSH and SRH
- 8 members of staff
- 662 active volunteers Trust-wide at end of April
- On average 2317 hours contributed by volunteers in April across the Trust
- 33.42% volunteers are aged <55 years old and 63.26% are aged >55 years old. The largest age group currently active are 71-80yrs
- 50% of the Trust's volunteer population are women *(inc. Trans women).* However, 26.79% of volunteers did not supply this information on application

Development of the Strategy: The Theory

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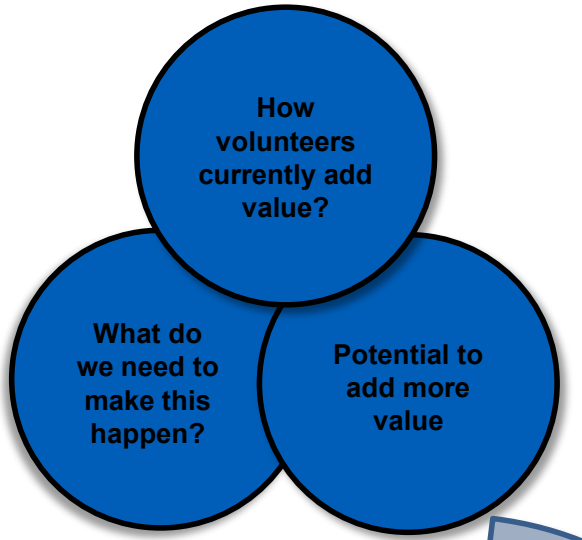
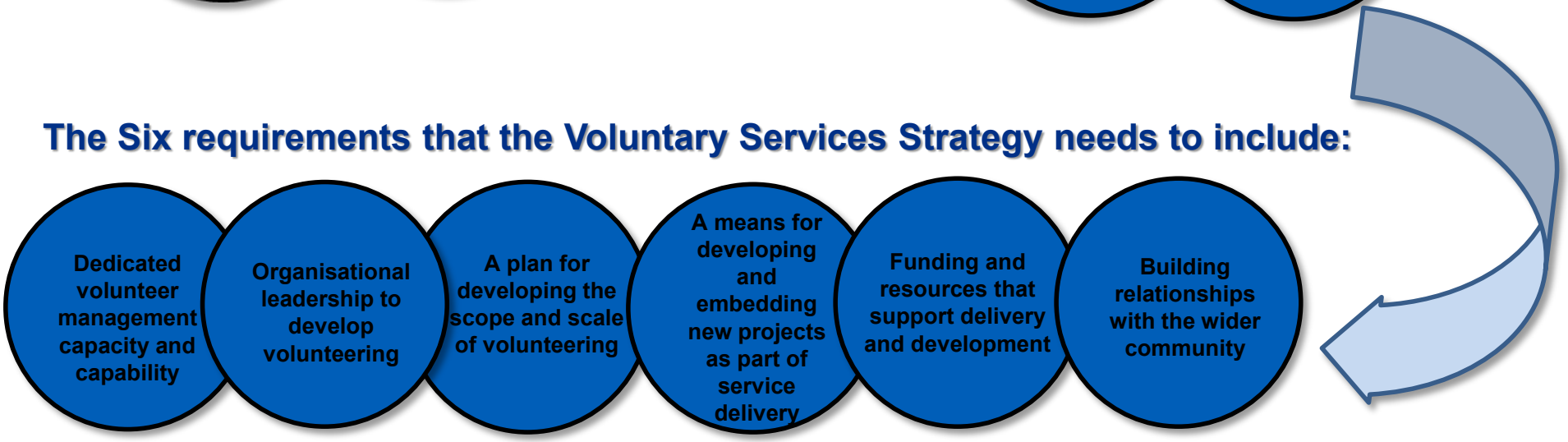
NHS Foundation Trust

The Three Pillars of Maximising Impact

Current Assessment & Audit of VS at UHSx



The Six requirements that the Voluntary Services Strategy needs to include:



How can a strategic approach to volunteering in NHS trusts add value? *The Kings Fund. Helen Gilburt Jake Beech May 2022*

Development of the Strategy: The Process

University Hospitals Sussex NHS Foundation Trust

Process Stage	What?	How	When
Induction	What is VS right now? Who are our volunteers? What are they doing? What impact are they making?	Interviews and informal conversations	Jan-Mar
Observation	How is VS currently run, what works and what doesn't work? What is beneficial for staff and the volunteers? What is efficient and cost-effective?	HoVS spends one day a week in each VS office. - Weekly VS catch Ups - Bi-monthly VSM meetings - Bi-monthly departmental meetings	On-going
Consultation	Interviews Surveys Focus Groups	Interviews taken place with: VS Staff, Volunteers, Partners, Trust Staff – clinical & non to gauge current climate of support and the service Focus Groups with key stakeholders on the strategy (July)	Jan-Mar & Qtr 2-3
Change	What change can be implemented now?	- VSM for RSCH & Brighton recruited (starts Aug) - New admin processes implemented cross-site - VSM's working collaboratively - Partner organisations re-introduced to VS via governance processes - substantive staff posts being filled	April – Aug & on-going
Knowledge	What is the current level of knowledge in the team – who are the subject experts? What can we learn from our peers and other Trusts? Where and who can we learn from?	- membership of NAVSM, AVM, NCVO, Helpforce and NHS Futures completed	Mar-May
Recommendations	What are we aiming for? What should VS in the NHS look like in the next 5 years?	NHS England Long Term Workforce Plan NHS England Volunteer Taskforce	April – July
Planning	How do we implement everything we're learning?	VS departmental Operational Plan Site Operational Plans based on 7 strategic foundations	June-Dec & On-going

Voluntary Services in the NHS England Long Term Workforce Plan

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Volunteers help improve services across the NHS, and support better outcomes for patients and the wellbeing of staff but, as seen during the pandemic, also provide additional capacity and flexibility in how services are delivered.

Volunteering can also improve people's mental and physical health, and gives them the opportunity to acquire skills that enhance their ability to gain employment.

Volunteering opportunities are an important aspect of the NHS's role as an anchor institution.

However, support for volunteering varies across NHS organisations and potential volunteers often find it difficult to find the right opportunity. As a result, the NHS has not fully tapped the true potential of volunteering, both its impact on service delivery and patient experience, and in providing a route into the NHS workforce.

2. Train – Growing the Workforce: Leveraging the Impact of Volunteers 65.&66.

NHS England Volunteer Taskforce 4 Key Ambitions

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To frame its work, the Taskforce developed a five-year vision for volunteering in the NHS by 2028. This set out its key ambitions for volunteering to be recognised as a key contributor to:

- **Improve patient experience and outcomes**
- **Better staff experience and wellbeing**
- **Reduce pressure on staff and services**
- **Improved volunteer wellbeing alongside the acquisition of skills, experience and confidence**

Volunteering is currently fragmented across the NHS. By 2028, Volunteering should be recognised equally across England, with investment to ensure the maintenance of appropriate volunteering infrastructure.

Barriers to volunteering will have been reduced so that anyone who wants to volunteer will be able to do so, while maintaining a safe experience for everyone.

NHS England Volunteer Taskforce
4 Recommendations for moving forward

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1. **Data and measurement** – NHS England should develop consistent and appropriate measures as part of workforce returns to track number of volunteers, volunteering hours and diversity data.

2. **Leadership** – NHS England should establish and maintain an influential network of ICS leaders, clinicians and experts to champion volunteering and the role of the VCSE, enabling their peers to understand how investment in volunteering can contribute to improved outcomes for patients and staff.

3. **Volunteer experience** – NHS England should increase access to health and care volunteering opportunities by simplifying volunteer recruitment processes, enabling organisations to 'share' volunteers to meet changes in demand, and developing national volunteer experience standards that organisations can sign up to.

4. **Resilience and emergency support** – NHS England should use learning from the pandemic to ensure it can stand up appropriate national volunteer and VCSE support swiftly in an emergency.

UHSx as an Anchor Institution

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NHS Foundation Trust

UHSx has an **important presence to play**: being a large-scale employer, one of the largest purchasers of goods and services in the locality. Controls large areas of land and has relatively fixed assets. UHSx is **tied to a particular place** by its mission, history, physical assets and local relationships.

As a significant Anchor Institution in the South East, UHSx have a responsibility to deliver in this space – Volunteers can play an active part in doing so in making contributions aligned with the paid workforce but also in supporting it.

Bringing current practices together, streamlining process and approach. And reaching out into the community to collaborate closely, effectively and with impact.

By choosing to invest in and work with others locally and responsibly with Volunteers, the NHS can have an even greater impact on the wider factors that make us healthy.

Building healthier communities: the role of the NHS as an anchor institution Reed, Gopfert, Wood, Allwood & Warburton April 2019

UHSx as an Anchor Institution in practice in Voluntary Services

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Example	Actual
Targeting positions for local people	Designing roles and activities that offer a more diverse volunteering experience e.g. the LMB Heritage Space, Micro-volunteering opportunities, Emergency/BCI support roles and coordination and fundraising support for events and income generation.
Understanding local demographics & opportunities	Using the Assemble Volunteer Management System more proactively to measure demographics, impact, population numbers, the contribution of volunteers in attendance, time and impact - not only what we have but also to gaps from our communities we *should* be engaged with and report on as such.
Creating pre-employment programmes, work placements & volunteer work experience **Engaging young people & supporting career development**	Working in collaboration with the Widening Participation team, local schools and college to design, promote and deliver strategic placements and opportunities for the benefit of the individual student as well as UHSx To measure and report on the "*volunteer to career*" route for progression of students who are placed in volunteering roles and then move into successful clinical careers – use as case studies, recruitment tools to show UHSx is a model Trust to be a part of as part of your education.
Supporting health & wellbeing of staff	Volunteer roles are supportive, not a replacement or alternative to a paid role but offer clinical and administrative staff the opportunity to work more effectively, allowing them to fulfil their role within the Trust to the best of their ability. Reducing stress, promoting a better sense of wellbeing and enabling staff to deliver the Trust's values and vision. Volunteers can offer a wider variety of skills and experience to enhance the workforce through wellbeing and practical support

How the Voluntary Services strategy supports the UHSx 5yr strategy

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1. **Planning:** departmental and individual site operational plans in place

2. **Discipline & Rigour:** we will work within a strategic framework that encompasses the NHS England and UHSx requirements with a clear supportive infrastructure to deliver our plans

3. **Collective Understanding:** we will be clear on what we are trying to achieve with aligned strategic and operational approaches alongside key collaborative departments and teams. Where we will see the clear impact of volunteers.

4. **Communication:** we will have one VS voice across the Trust, and we will keep the Volunteer voice at the heart of all that we do, with a clear brand and identity for all volunteers to be recognised in all they do.

5. **Collaboration:** with one VS voice, our aims and objectives will be clear to all those we work with internally and externally

6. **Hearts & Minds:** Volunteers will be recognised as a key part of the UHSx workforce. Volunteers will be proud to be a part of our community and we will be THE No.1 place to volunteer, as an integral part of the “anchor institution” for our communities.

Voluntary Services Strategic Approach 2025-2030: How we will work

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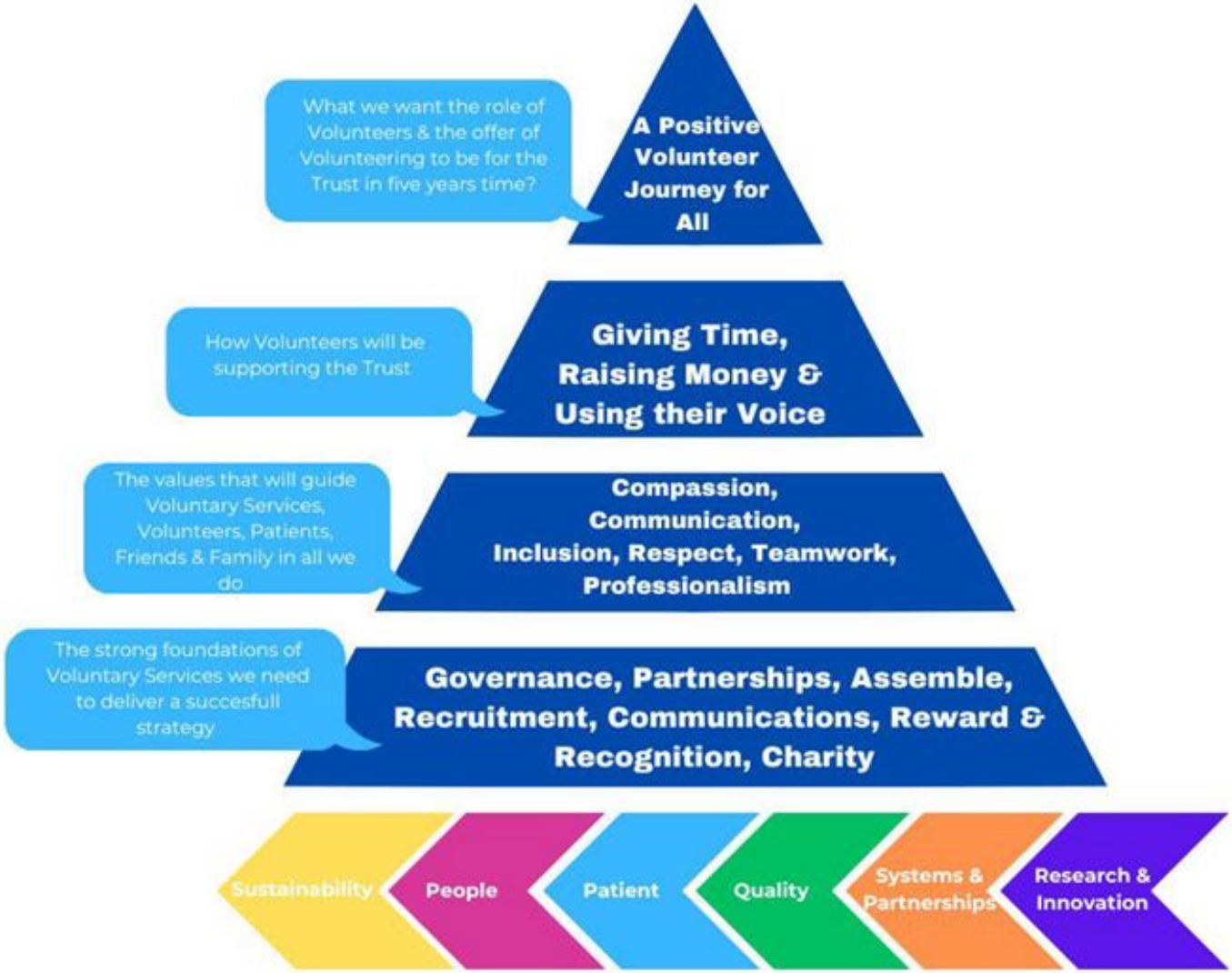

Voluntary Services Foundations:
What the strategy will operationally be built on

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Pathway	Route
Governance	To ensure the VS programme and all it offers is robust and grounded in the correct governance, training and legislation for volunteers, staff and all those we support in VS
Partnerships	To establish a central library on behalf of the Trust, with the correct and relevant documentation to support all staff and volunteers of partnership VSCE organisations who operate on Trust property. Ensuring that signed and completed MOU's are in place for all.
Assemble	To get the Assemble VMS to a usable standard for all staff. To ensure all Volunteers are entered onto the platform and have access & training to coordinate their own volunteer journey with the Trust. Enabling us to have accurate reporting to measure the impact and contribution of volunteers to the Trust, as required by NHS England.
Recruitment	To establish consistent, short and effective recruitment pathways, procedures and processes for all Volunteers (and those partners we recruit for) across the Trust.
Communications	To establish a Trust-wide communications plan across all mediums, to ensure that all parts of the volunteer journey and its successes are shared internally and externally.
Reward & Recognition	To ensure that the efforts of all volunteers and those staff supporting them are recognised and rewarded consistently using a variety of methods, resources and communications.
Charity	To support the Charity in a variety of roles and functions to enable them to increase the income to be raised in aid of My UHSx

VS Strategic Priorities 2025-2030:

Where we will prioritise our work

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We will design, implement and deliver on 5 strategic priorities to support the Trust over the next 5 years. These areas will concentrate on areas of need, growth, development and opportunity for Volunteers, Voluntary Services, Staff and ultimately for the benefit of our patients from within our communities.

I. **Supporting Emergency Departments**

I. **Supporting Patient Flow**

II. **Supporting Patient Experience**

We have been approached by Helpforce as they are in discussion with Sussex ICB about a 3-year funded programme that will extend work they have been doing in ESHT in the past months as well as enable working with other Trusts in Sussex - to create a cohesive model of volunteers and VCSE's supporting patient flow and discharge within the Trust.
This programme would enable part of the first 3 strategic priorities to be delivered, with potentially £100k funding over three years, building on work that is already in progress within VS across all sites.

This will also include Winter Planning priorities as standard, so we have a volunteer-involving process in place for that too.

IV. **Making Volunteering Rewarding for Everyone**

V. **Collaborating with MyCharity UHSx**

How Helpforce will support us

We will codesign a 3 year plan covering the following areas:

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1. Working with VS at UHSx to identify volunteer roles that are a strategic and operational fit for the organisation, centred around improving patient flow/ discharge pathways and patient experience

2. Exploring opportunities to better integrate local VCSE services within discharge pathways, strengthening collaboration between the NHS and VCS to improve patient outcomes

3. Design the identified volunteer roles with VS, building on learning and resources from Helpforce's experience elsewhere to support implementation at pace

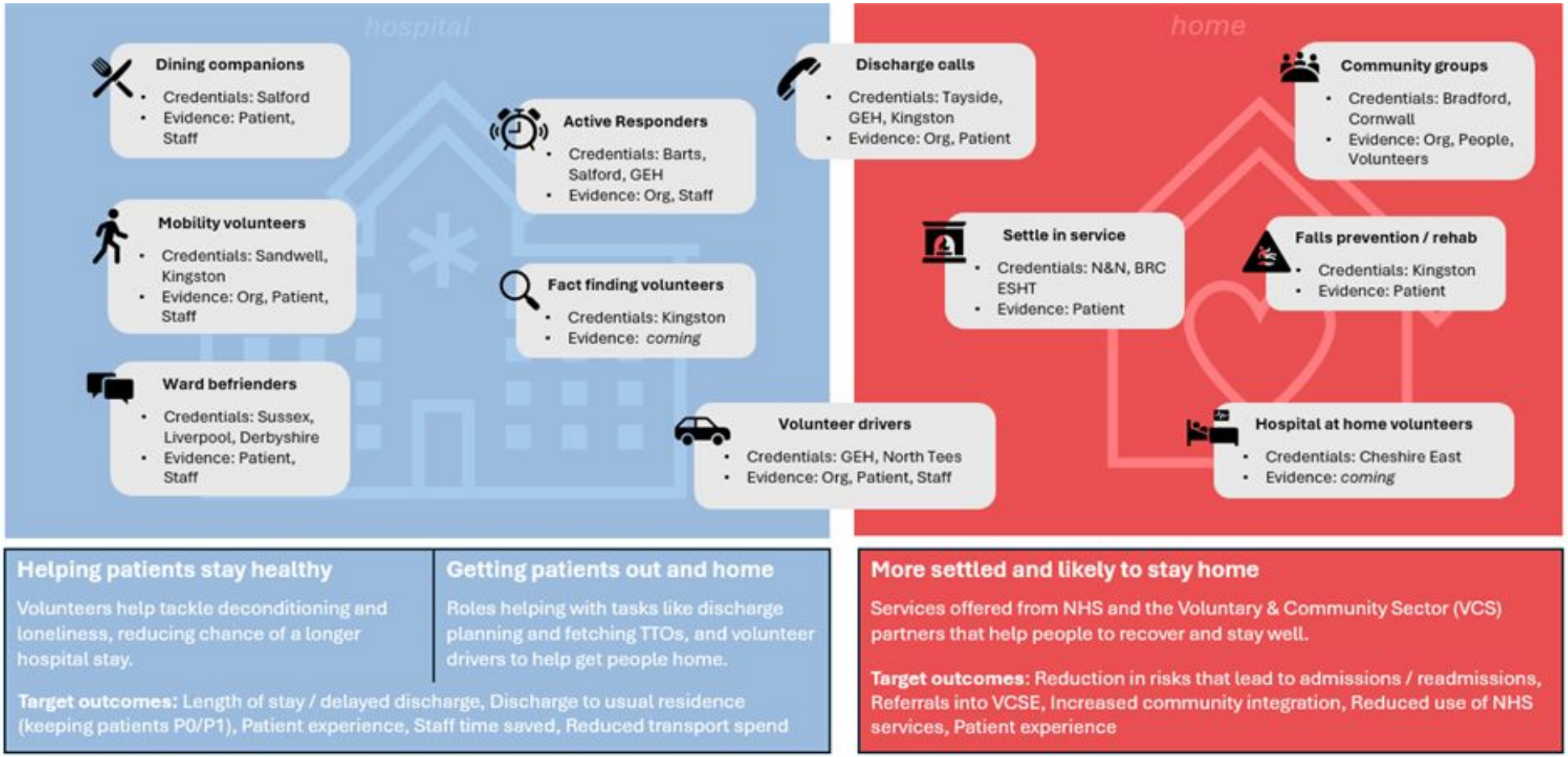
4. Support VS to monitor the impact of these roles are having and continuously improve them

5. Undertake an independent evaluation of the volunteer roles, demonstrating the impact they have on patient experience as well as on operational pressures associated with patient flow and discharge pathways.

Menu of suggested volunteer roles to support patient flow and discharge

University Hospitals Sussex NHS Foundation Trust

The following illustration shows an array of volunteering roles or VCSE services that can assist patient flow and discharge. We can also explore implementing services that support patient flow further upstream, such as community outreach initiatives and preventing non-attendance.



helpforce

Strategic Priority 3:
Supporting Patient Experience

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As well as potentially supporting Patient Experience via the Help force funded programme, we can also grow the Volunteer offer to support several PE activities and deliverables, including:

- Volunteers being key conduits and participants in the Welcome Standards Training
- To develop volunteer roles that support the Friends & Family Test, meal time coordination and support
- To explore volunteer translator roles that reflect the wide diversity of our hospitals and the communities they are a part of
- To explore Volunteer Contact centres for DNA, Follow-up appointment calls, surveys etc.
- To work in collaboration with Chaplaincies to ensure volunteers are part of an individuals' patient experience, where appropriate. And provide the required emotional and wellbeing support that this area of the Trust's work requires.

Strategic Priority 4:
Making Volunteering Rewarding for Everyone

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Volunteering is about people and relationships, so it is important to ensure that, that is at the heart of what we do. Individuals giving their time should not be taken for granted nor go unacknowledged. Support, Communication, information and advice are all key components to volunteer retention.

As part of this priority we will:

- To have a standardised cross-site Recruitment, On boarding and Off boarding process with agreed SLA's for VS, applicants and partner organisations to adhere to.
- Have 5 On boarding & Engagement Coordinators employed to cover all sites, supporting all volunteers who carry out activities on behalf of the Trust
- Hold frequent meet ups and coffee mornings for all Trust and partner organisations and their volunteers
- To design and implement a Reward and Recognition matrix for the Trust, to include various cost-effective resources to ensure all volunteers are thanked for all that they do.
- To organise a yearly volunteer conference, where the volunteer voice is at the heart of that we do.

Strategic Priority 5:
Collaborating with MyCharity UHSx

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As a key part of the VS strategic mission is to **Raise Money**, we will work collaboratively with our Fundraising and Communications colleagues to support charitable activities to enable an increase in funds to be raised. Including:

- Designing and recruiting Exhibition volunteers to coordinate visitors to the LMB Heritage Space
- Recruiting charity volunteers who can promote the charity in pivotal locations across all Trust sites
- Design and recruit to a micro-volunteering offer to support all charity events and fundraising activities. This allows a more diverse volunteering offer from the Trust and the opportunity for us to recruit from our local communities and their varied demographics and skill-sets.
- To design and establish a corporate volunteering offer for all local companies and businesses who wish to support their local hospital through giving time, as a means to building on a financial/sponsorship relationship with the Charity.

Governance Assurances

Ensuring compliance and best practice within Voluntary Services

University Hospitals Sussex NHS Foundation Trust

There are various requirements and standards that Voluntary Services at the Trust must uphold to demonstrate good governance, best practice and ensure safety and compliance within any Trust setting, reagrdless of a role being in a clinical or non-clinical setting.

For the safety of volunteers, patients, staff and visitors to all hospitals within the Trust, we will be establishing various protocols, which must be adhered to by all registered volunteers and those Voluntary partner organisations, who deliver activities on Trust property with whom we work in frequent collaboration with.

The standards required in the recruitment of Volunteers to any Trust, from NHS England are:

- **DBS Clearance**
- **The completion of Statutory and Mandatory Training**
- **References**
- **Occupational Health check and health clearance**

We have now re-designed the recruitment process to make it Trust-wide and are reviewing the above requirements with colleagues in the relevant areas. To make the process more efficient, practical, fair and accessible for all who wish to volunteer for the Trust, regardless of the role they choose to carry out, whilst retaining the required standards from NHS England.

Voluntary Services in 2030: where we will be

University Hospitals Sussex NHS Foundation Trust

- "*A Positive Volunteer Journey for All*" delivered across the Trust

- Volunteer activity coordinated across the Trust delivering a proactive, outreach support service via investment in specialised more outreach staff roles to increase reach, delivery and effectiveness of the service across:
  - For all Brighton hospitals and centres
  - Princess Royal Hospital
  - Worthing
  - Southlands
  - St. Richards

- Volunteer roles will reflect strategic need and be measurable, with impact reported on and shared across the Trust, especially with the Volunteers to enhance and fulfil their volunteering experience.

- We will have 2017+ volunteers actively contributing to the Trust in roles that can visibly demonstrate strategic and operational impact to Staff, Patients, Partners, Friends and Family members as recommended in the NHS Long-term Workforce Plan (*based on a 25% increase in volunteers, year on year with a predicted attrition rate of 71% taken from The Community Life Survey 2024)*

- We will have equitable representation of ages <55 and 55> at and our volunteers will be representative of all our local community ethnic backgrounds from across the Trust's geography.

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EMERGENCY PREPAREDNESS, RESILIENCE and RESPONSE ANNUAL REPORT 2024

Mark Stevens, Head of EPRR

Public Board – 6th February 2025

1. INTRODUCTION

1.1 The NHS must be prepared to respond to various incidents and emergencies that could impact health or patient care, such as extreme weather, infectious disease outbreaks, major transport accidents, cyber security incidents, or terrorist acts. This readiness is supported by legislation including the CCA 2004, the NHS Act 2006, and the Health and Care Act 2022.

1.2 Evidence indicates that effective planning and preparation save lives and speed up recovery. All NHS-funded organisations must ensure robust, well-tested plans are in place to handle these situations.

1.3 The NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) outline the minimum requirements for NHS-funded organisations. These standards comply with the CCA 2004, 2005 Regulations, and the NHS Act 2006, and all healthcare providers must demonstrate annual compliance.

1.4 Nationally, there is increasing focus on the guidance and range of threats requiring preparedness. The Trust must maintain its reputation in EPRR and contribute to regional preparedness.

1.5 This report covers the Trust's EPRR activities from 01 January 2024 to 31 December 2024, detailing plans, responses to incidents, and compliance with EPRR Core Standards and statutory requirements.

2. RECOMMENDATIONS

2.1 The Board is asked to NOTE and endorse this EPRR annual report.

3. CONTEXT

3.1 The EPRR Team met the portfolio demands, ensuring readiness and resilience in response to disruptions or emergencies affecting service delivery. Key areas covered in this report include:

- EPRR Assurance
- Risk Management
- Policies and Plans
- Business Continuity
- Training and Exercising
- Incidents
- Events
- EPRR Work Programme

4. MAIN REPORT

4.1 EPRR Assurance

4.1.1 The NHS England Core Standards for EPRR specify the minimum requirements for commissioners and providers of NHS-funded services.

4.1.2 Due to the extensive collaboration between the Emergency Preparedness, Resilience and Response (EPRR) team and NHS Sussex, UHSussex received a fully compliant rating in the EPRR Assurance Process. This rating was endorsed and validated by the NHS Sussex EPRR Team, recognizing the efforts of the Trust's EPRR team.

4.1.3 Out of the 62 Core Standards relevant to Acute Trusts, UHSussex provided sufficient evidence to meet the minimum requirements, achieving full compliance with all standards.

4.1.4 However, some areas were identified for additional work with advisories from NHS Sussex being placed against 7 of the standards.

4.1.5 The EPRR annual work programme will be updated to ensure all advisories are completed for the next EPRR Assurance.

4.2.6 As part of the EPRR Assurance, Trusts must complete a Deep Dive into a specific area each year. In 2024, the focus was on Cyber Security. The EPRR Team worked closely with the Trust Information Management and Information Governance teams to complete this Deep Dive.

4.2.7 Of the 11 deep dive standards, the Trust was partially compliant with six standards and fully compliant with five.

4.1.8 The EPRR team will work with the Chief Information Officer and the Information Governance Manager to address the Cyber Security Deep Dive standards in line with the Data Protection Security Toolkit (DPST) and annual EPRR Assurance requirements.

4.1.9 Should NHSE issue further guidance resulting from the Cyber Security Deep Dive, the EPRR team will work with the Chief Information Officer and Information Governance Manager to meet any new requirements.

Risk Management

4.2.1 The National Security Risk Assessment (NSRA) and National Risk Register (NRR) are reviewed every two years. The NSRA was published in autumn 2022, and the NRR on 03 August 2023.

4.2.2 Risks identified in these assessments are addressed at the Local Resilience Forum (LRF) via the Community Risk Register, with plans and procedures developed for the most likely and high-impact risks. NHS-funded organisations contribute to the Community Risk Register through multi-agency planning within each LRF.

4.2.3 The UHSussex EPRR Team represents the Trust in the Sussex Resilience Forum Risk Group and the Local Health Resilience Partnership Risk Task and Finish Group. The team also participates in the UHSussex Health and Safety Committee.

4.2.4 Emergency Planning and Business Continuity Risks are recorded in the EPRR Corporate Risk on SHE – Assure Risk Management system and as individual risks on the IQ Datix system. These risks are reviewed and updated per the Trust's Risk Management Policy and Emergency Preparedness, Resilience and Response Policy, or as needed following an incident or changes in national guidance.

4.2.5 The EPRR Team attends the UHSussex Health and Safety Committee and reviews the EPRR Corporate Risk Assessment, submitting reports to the committee.

4.3 Policies and Plans

4.3.1 The Trust maintains a comprehensive suite of EPRR policies and plans to address Critical, Business Continuity, and Major Incidents.

4.3.2 All EPRR policies and plans have been reviewed and updated to ensure they are current, conform to existing guidance and legislation, and are relevant to UHSussex. Policies and plans are also reviewed following any incident, with lessons learned and recommendations addressed as necessary.

4.3.4 The EPRR team collaborates with partners across the NHS Sussex health system, the Sussex Resilience Forum, and other agencies in developing and reviewing EPRR policies and plans.

4.3.5 The annual EPRR Work Stream lists all EPRR policies and plans, with review dates. Those requiring review and update during 2025 will be identified in the 2025 work stream.

4.3.6 Task and finish groups have been established for detailed planning and review of the following plans, ensuring required detail and processes are in place:

- Lockdown
- Mass Casualty
- Evacuation and Shelter

4.4 Business Continuity Management

4.4.1 Business Continuity procedures are deeply embedded within the Trust, supported by clear and comprehensive EPRR and Business Continuity Management policies that delineate between policy and operational plans.

4.4.2 The following documents were reviewed, updated, and approved for UHSussex in 2024:

- Business Continuity Management Policy
- Corporate Level Critical Activities
- Trust Business Continuity Plan

4.4.3 A Business Continuity Audit was carried out by the Trust Auditors in November 2024, with the final report published in January 2025.

The audit identified five findings: two assessed as high and three as medium. It also highlighted areas of good practice within divisions but noted a lack of consistency and review of Service Level Plans, as well as a lack of staff knowledge and shared learning.

4.4.4 The EPRR team is committed to integrating the findings from the Business Continuity Audit into the EPRR annual work programme. Additionally, the team will concentrate on the following priorities to ensure that Business Continuity and related service level plans remain current and effective:

- Updating and reviewing business continuity plans regularly.
- Ensuring all staff are trained on the latest protocols.
- Conducting regular exercises and drills to test and refine response strategies.
- Collaborating with stakeholders to address any identified gaps or areas for improvement.

4.5 Training and Exercising

4.5.1 The Emergency Preparedness, Resilience, and Response (EPRR) team successfully accomplished several key objectives in 2024:

- **Meeting Occupational Standards**: Ensured that on-call staff met the NHSE minimum occupational standards (MOS) required by the EPRR Assurance.
- **Training Initiatives**: Offered the Principles of Health Command Training (PHIC) course to all on-call managers, directors, and executive staff, with several participants attending in 2024.
- **eLearning Development**:
  - Introduced an induction eLearning package on the induction welcome page.
  - Provided initial incident management guidance for Service/Department leads at Southlands Hospital.

- Created an eLearning package for reception staff managing patients with injuries or illnesses due to hazardous materials.
- Developed a guide to writing service-level business continuity plans.

4.5.6 The NHS England EPRR Framework mandated specific emergency planning and business continuity exercises, resulting in 6 tabletop exercises, training 37 staff members and a Trust-wide communication exercise to test the call-out cascade.

5. Incidents

5.1 During 2024, the Trust demonstrated its resilience with the Emergency Preparedness, Resilience, and Response (EPRR) team playing a vital role in assisting leadership teams to effectively manage a wide range of incidents.

5.2 The response to these incidents highlights the Trusts dedication to maintaining high standards of care and operational efficiency even under challenging circumstances.

5.3 Debriefs

5.3.1 Debriefs have faced challenges due to operational pressures and Industrial Action, making it difficult to hold specific debriefs following some incidents. While some debriefs have been completed, others remain outstanding.

5.3.2 Debriefs play a crucial role in understanding the events, identifying lessons learned, and incorporating improvements into future training and processes.

6. Events

6.1 The EPRR team gathered information from the seven Local Authority Safety Advisory Groups (SAGs) within the Trust's geographical area. This ensured event organizers provided adequate medical provisions and had robust plans to mitigate any potential risks to the health system from large events.

7. EPRR Work Programme

7.1 After each annual EPRR Assurance, an EPRR action plan highlighting key focus areas is developed. This plan includes recommendations from the EPRR Assurance advisories and findings from the Business Continuity Audit. These actions become part of the EPRR annual work programme.

7.2 Progress against the EPRR work programme is monitored through EPRR team meetings and the EPRR Committee.

8. Next Steps

8.1

- Develop and implement the updated EPRR Work Stream for 2025 to ensure completion of all EPRR Assurance advisories before the 2025 Assurance.
- Continue to develop EPRR training with the creation or more eLearning courses and scenario based face to face training

- Continue collaborating with the Lockdown Planning Group to advance the Lockdown Plan for UHSussex.
- Work closely with Fire Safety (when appointed) and Estates and Facilities to finalise the Shelter and Evacuation Plan for UHSussex by the 2025 EPRR Assurance.
- Collaborate with the Mass Casualty Steering Group to address all advisories from the 2034 EPRR Assurance, and to finalise the Trust Mass Casualty Plan and action cards/departmental service plans for the 2025 EPRR Assurance.
- Review and update all EPRR Policies and Emergency Plans as necessary throughout 2025.
- Ensure the completion of all recommendations from the Business Continuity Audit and that all departments review and comply with Business Continuity Service Level plans during 2025.
- Approve the revised terms of reference for the EPRR Committee and implement the committee meeting cycle for 2025.

8.2 This report highlights the work of the EPRR team over the past year to ensure the Trust is prepared to respond to any incidents and emergencies. It shows the team's commitment to capturing and acting upon lessons learned from any incidents, feedback from training courses and ensuring compliance with statutory requirements and legislation.

Mark Stevens, Head of EPRR, 31st January 2025